STATE OF CALIFORNIA
MANAGED HEALTH CARE IMPROVEMENT TASK FORCE

STUDY SESSION

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Oakland Scottish Rite Center
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Oakland, California 94612

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CHAIRMAN ENTHOVEN: Good morning. I'd like to call the meeting to order and ask the members to please take their seats and also the general public.

Let me say that today we have a very full schedule, but this meeting marks a departure from the past in that it will not have for the most part external presentations by invited experts, but instead we will be focusing mainly on exchanging ideas among members of the task force and Dr. Romero, our own Dr. Romero, who will be talking about options for organizing the government to regulate managed care.

I'd like to welcome the members of the general public who are here. We're very happy to have you with us and feel honored by your interest and attention.

I do want to say, however, that the meeting is primarily intended for -- we call it Study Session -- primarily intended for members of the task force to interact and discuss the work in progress that they are developing, and we've scheduled only a very limited time for a commentary by the general public. When it comes to that time a little before lunch, I would like to ask you to make your comments very brief. We have speaker cards which we asked you to fill out for you to make your comments very brief and concise.

If you have spoken to us before, we would appreciate if you would just identify yourself and say, you know, you want to amplify previous remarks, but not

take us through what we've heard already. If some previous speaker has already said what you have in mind, we would appreciate it if you would just say I agree with so and so who talked about whatever it was and thereby save time for other members of the public who also want to speak because the amount of time that we've allocated to this is quite limited because, as I say, our main purpose here today is a Study Session among the task force members.

So our plan to begin with is going to be a presentation by Dr. Romero on alternative ways that the government, state government, might organize for the regulatory admission.

We'll follow that at about 11:40 by a brief presentation by Dr. Helen Schauffler who has done a yeomanish job of distilling the many and conflicting comments and views of the different members of the task force into a survey which is about ready to be launched now. In fact, it has been in part tested. So Dr. Schauffler will tell us where we are.

Then we will have some time for commentary by the general public. Then we will break for lunch, and after lunch we will resume to take up work of our Expert Resource Group on consumer choice, provider incentives. I hope we'll get back to dispute resolution, and a New Quality Information.

So for the task force members this is a very important opportunity for you to interact with your

colleagues who are developing analyses, ideas, proposals, within the particular area that they're working on. And it's an opportunity for you to ask questions, to make comments, express your views, develop and shape the product that is emerging.

Eventually, the completed products will be circulated to you for your review and detailed comment back to the authors who will then rework it again, and then we hope we move through some kind of consensus pieces, then we'll bring them back for review and approval by the task force, and eventually we will put each piece of this in a vote to the task force.

Since our last meeting, we've, to my regret, we had the resignation of Kate Murrell who has retired from the Fireman's Fund and is on her way to Texas. I'm happy to say that we have found a replacement in Jennifer Loucks who is now being reviewed by the governor's office and who is also associated with Pacific Business Group on Health and has the same expertise that Kate Murrell brought to our deliberations.

I'm feeling cautiously optimistic that we will find a good deal of common ground and emerging consensus on some of the lines of progress in how to improve the regulation of the managed care of the state.

Another news item is that Helen Rodriguez-Trias, who is off on vacation right now, has persuaded me that we really ought to do a paper on

women's health. And with good help from Sara Singer we've been able to identify a person Margaret Deller who is going to join us and work on that.

I expect we will probably be establishing an expert resource group on that. It took me a while to get the message or get when I was first -- when I was first hearing it. I thought that this was some kind of exotic attack on managed care which was, you know, meant to be disadvantageous to women. But when I reached out to friends, in some cases former students many of whom are women, and some of them explained to me that along the following lines which is that a number of characteristics of our formerly male-dominated health care system had been really quite negative to the particular needs of women in particularly the characteristics of having, you might call it, professional silos of care.

And so for people who particularly need integrated services, you picture the mother who's got the adolescent small child and the mother who has health needs if she wants to get off of work and come in and get some kind of coordinated response to her multiple problems. And you think about how that plays against our traditional health care system that is just very unresponsive, not in all cases, but in many cases very unresponsive for that kind of need for a coordination and customer service.

And I think it presents a very nice issue

to think about the potential for managed care. So what my friends have told me is this is not to say that managed care is somehow going to be worse for women. In fact, Helen Schauffler's presentation shows in many cases managed care is doing a much better job in terms of preventive care such as mammograms, Pap smears, prenatal care, and so forth, but rather than women do not want managed care to inherit a lot of the negative features of the previous system and want to see somehow managed care becomes more responsive to their needs for better coordination. I'll be brief on that problem now. So we will be working on that when Helen and I both get back from our vacations, we will be talking about how to constitute an expert resource group in that area.

So without objection or further delay, I'd like to call -- oh, let's see. All right. I'm going to call Phil Romero, the executive director, for his report. Dr. Romero?

DR. ROMERO: Thank you, Dr. Enthoven. First of all, I think we need to call the roll; is that right? Okay.

Can I ask -- can I ask for Flo, would you briefly take attendance, call the roll.

MS. NEFF: Task force members, please say --

DR. ROMERO: Flo, one suggestion, why don't you come and take my seat so that people can hear you well. It's a big room. Oh, sure great.

MS. NEFF: Okay one more time, may I ask the task force members to please say "present" to signify your presence. Alpert?

DR. ALPERT: Present.

MS. NEFF: Armstead?

DR. ARMSTEAD: Present.

MS. NEFF: Bowne?

MS. BOWNE: Present.

MS. NEFF: Conom?

(No audible response.)

MS. NEFF: Decker?

MS. DECKER: Present.

MS. NEFF: Enthoven?

DR. ENTHOVEN: Present.

MS. NEFF: Farber?

(No audible response.)

MS. NEFF: Finberg?

MS. FINBERG: Present.

MS. NEFF: Gallegos?

(No audible response.)

MS. NEFF: Gilbert?

(No audible response.)

MS. NEFF: Griffiths?

(No audible response.)

MS. NEFF: Hartshorn?

(No audible response.)

MS. NEFF: Hauck?

(No audible response.)

MS. NEFF: Hiepler?

MR. HIEPLER: Present.

MS. NEFF: Karpf?

DR. KARPF: Present.

MS. NEFF: Kerr?

MR. KERR: Present.

MS. NEFF: Lee?

MR. LEE: Present.

MS. NEFF: Northway?

DR. NORTHWAY: Present.

MS. NEFF: O'Sullivan?

(No audible response.)

MS. NEFF: Perez?

(No audible response.)

MS. NEFF: Ramey?

MR. RAMEY: Present.

MS. NEFF: Rogers?

(No audible response.)

MS. NEFF: Rodriguez-Trias?

(No audible response.)

MS. NEFF: Severoni?

MS. SEVERONI: Present.

MS. NEFF: Spurlock?

DR. SPURLOCK: Present.

MS. NEFF: Tirapelle?

(No audible response.)

MS. NEFF: Williams?

(No audible response.)

MS. NEFF: Zaremberg?

(No audible response.)

MS. NEFF: And Zatkin?

MR. ZATKIN: Present.

MS. NEFF: And I'd ask that the ex officio members to do the same. Belshe?

(No audible response.)

MS. NEFF: Berte?

(No audible response.)

MS. NEFF: Bishop?

(No audible response.)

MS. NEFF: Knowles?

(No audible response.)

MS. NEFF: Rosenthal?

(No audible response.)

MS. NEFF: Shapiro?

MR. SHAPIRO: Present.

MS. NEFF: And Werdegar?

(No audible response.)

DR. ROMERO: Thank you, very much. Flo's act has manifest my first announcement because we've had a personnel change in staff. Jill McLaughlin our former task force secretary has moved on to the private sector. I think in Flo we have found one of the few people that can meet Jill's high standards, and we welcome her to the task force staff.

Second, for those of you who like me are internet junkies, I'm happy to report the task force now

has a web page, and I'll let Alice Singh give you brief words about that.

MS. SINGH: The task force has now entered cyber space. After much work and effort and cooperation with OSHPD and specifically Glenn Teeg. If she's here, I'd like to acknowledge her. If she would stand. Thank you.

Glenn has done a wonderful job for us in assisting us in the development of our web page. I will read the address. It's extremely long. I will read it once, and if you'd like to get it from me during the lunch break, that would be fine. It's http://www.chipp.cahwnet.gov/mctf/front.htm.

We will be linking up to several other sites so there will be an easier way to get to our page, but we wanted to announce that it has been finalized and is available for your review. We'll have several documents including upcoming meeting agendas, minutes, and other varying informational documents available. So please take a look at it, and thank you very much Glenn again.

CHAIRMAN ENTHOVEN: I've already visited the web site, and it's really great. It has some information that I hadn't known about, so I thought browsing it was very useful. In fact, I might just pick up on that and say I think that the internet has tremendous potential for getting a lot of information out there in ways that we hadn't thought of before, and

I think that will relate to our task force work.

Some people have the instant reaction, "Oh, only 10 percent of the population are on the internet or something." But I think, in fact, it would be a way we could get to information to employee benefit offices who could then make it readily available to employees and to libraries where it is now, so that citizens who want to come in and find out more about the health plan. It's a great way of keeping information on line and available.

Okay. Let's see, we were going to go immediately to Managed Health Care Oversight. I've just been notified the catastrophe which is that the relevant papers are locked in a car, and AAA isn't going to be able to break open the car for a half hour. So we can't present -- what do we do? Should we go ahead -- do you want to go ahead and present it without papers?

DR. ROMERO: I'm prepared.

CHAIRMAN ENTHOVEN: Okay. Well, Dr. Romero had notes -- what the paper, oh, well, okay, background organization of state regulation of managed care. Okay. So Phil?

DR. ROMERO: I would prefer not to use a microphone if everyone can hear me. Of course, if you couldn't hear me, how would you know if I asked the question? All right. With that, Mr. Chairman, if you wouldn't mind pointing the microphone in my general direction for the benefit of --

CHAIRMAN ENTHOVEN: You're going to show slides right here?

DR. ROMERO: Exactly. To that end I would recommend those of you who aren't in the front row, since we've got a lot of empty seats, that you relocate yourselves to chairs --

MS. BOWNE: Are the slides there? Then we don't need to move.

DR. ROMERO: Okay. Now just before I get started, there are -- you've received two packets. One is called, "Background and Organization of State Regulation of Managed Care." It looks like this. The other is called, "Managed Care Improvement Task Force Questionnaire." It looks like this. And I'll be referring to both of them in this presentation.

Now, one of the issues that catalyze the creation of this task force in 1996, I think it's fair to say with the whole question of what state organization should retain responsibility for regulating managed care organizations. You've heard a lot --

CHAIRMAN ENTHOVEN: Use the mic.

DR. ROMERO: Okay. What state organization would -- this is kind of like theater. It's very interesting. What state organization would -- should have responsibility for regulating managed care organizations? As you know, the organization of the single greatest responsibility is the Department of Corporations, and we heard a presentation from Keith

Bishop and Commissioner of Corporations Warren Barnes. One of his attorneys at the June 20th meeting to give you some background how the Knox-Keene law, the governing law, which is the law Knox-Keene on prepaid health plans.

But as you have heard in bits and pieces, a number of other organizations have responsibilities as well. Because that was a catalyzing issue, I have always seen that we had a responsibility to -- this task force had a responsibility to make some recommendations on whether the status quo is acceptable or whether some change was necessary in the organization that should be responsible.

I'm not here to give you recommendations as to a specific alternative for one simple reason. That issue is entirely interdependent. That issue of who should regulate is entirely interdependent of two other questions.

One is, "What is the right regulation, i.e., what should the scope of their regulation be?" In the case of corporations, for instance, is it's one particular type of health plan, but there are many other segments of the health care system that have somewhat similar responsibilities.

I would point for those of who you haven't seen it, to an illustration in the Wall Street Journal yesterday, Loma Linda Hospital is getting the business of Barry Risk, and, therefore, operating in

some respects like an HMO. And the theme of the article was that many other providers either have or will be joining that hospital in the near future, so I don't want to see a lot of Loma Linda in particular. So the second question is, "What should the scope of that regulation be?"

The third one is, of course, "What should the overarching role of government or policy philosophy governing those regulations be?" Because I see them as interdependent what I want you to do today is not take the question of who should regulate in isolation because I don't think it should be treated in isolation.

What I want to do is give you some context and in part, well, to give you some context so that the task force can take up the specific recommendation near the end of its process circa November and December after it has made more substantive policy recommendations.

I'm going to do that in two pieces. First, I'm going to summarize to you what we found out you think. You will recall that in June we administered a Delphi questionnaire. Chairman Enthoven administered a Delphi questionnaire to you asking you some questions about your preference in this area.

First of all, just to give you a factual summary of what you said, and then I will take it to the next step in trying to interpret and read back to you some provocative ideas for options available in light of

what you recommended.

Now, let me enter to the slide portion with a brief digression. I'm a student of American popular culture particularly from the 1920s to the 1940s. So there -- I'm not old enough to know about directly, but I've read about a very well-known cartoonist by the name of Rube Goldberg.

Now, Rube Goldberg has become somewhat of a legend, so much so that he's become a cliche in the political circles. One of the fastest ways to criticize someone else's idea is to declare it a Rube Goldberg scheme. Many few of us know what a Rube Goldberg scheme means, so I thought I would show you what a Rue Goldberg theme means.

And bear with me for those in the back of the room while I read -- go through this diagram. "Professor Butts' landlady hits him over the head with a picture for nonpayment of rent. He discovers a sure way to keep his head down for making a golf shot." So this Rube Goldberg scheme, the purpose of it is to make you keep your head down in a golf shot. "Golfer (A) swinging club (B) hits branch of tree (C) shaking apples down on kettle drum (D). Caddy (E) hearing the noise thinks a thunder storm is approaching and runs to the clubhouse stumbling over golf bag and pushing flag pole (G) against the bag of peanuts (H), excuse me, which breaks and throws peanuts in basket (I). As squirrel (J) is up there. As squirrel (J) jumps into the basket

to get the peanuts his weight raises the end of paddle (K) and draws fish (L) out of water. A hungry seal (M) seeing the fish claps his flippers (N) for joy and causes a breeze to enter funnel (O) thereby blowing a hard grunt (P) which straightens out a dollar bill (Q) next to golf ball focusing eyes of player on this spot during swing."

Now, this stuff was a big hit in the 1920s. The fundamental source of the humor in this and all of Rube Goldberg schemes, it was fundamentally he took a very simple objective and designed a phenomenonally gratuitously complicated process to achieve that scheme.

Well, if Rube Goldberg were alive today, he might sue the State of California for copyright infringement with respect to state oversight managed care.

Now, for task force members who have handouts, I'm not expecting you to absorb the subject of the slide. It's there in your package. The point simply is that the box in the upper part of the chart is specific state organization. The ovals in the bottom of the chart are specific regulatory functions for regulatees. And what you'll note is that there's not a single organization responsible for a single coherent set of functions. There's a great deal of duplication and overlie.

Now, we asked you for your early thoughts

about this structure, and it's probably not too surprising that when we asked you the question, "Do you believe the current regulatory structure is working optimally?" Seven out of eight said "no."

Now, we didn't ask you the next question which was to list the reasons why you thought they were not optimalized in respect to there were so many reasons as mentioned here. But one aspect that we're talking about today is the organizational aspect.

We asked you the question, "Do you think that the HMOs should be regulated by the same agency as other managed care insurance entities?" And you said by -- five out of six of you said that the answer was "yes." So in that example, you're suggesting that there should be some consolidation across regulatory functions or across regulatees by the way it's said.

Now, another direction that the last one was in essence a question of vertical integration, "Do you believe that HMO regulation -- do you believe that prepaid health plan regulations should be consolidated to a single organization across plan types?" This is a vertical information question or vertical consolidation question. "Do you think the same regulatory authority should exercise oversight authority over the delivery system (i.e., medical groups) as well as health plans?" And again you fell by a five out of six margin that there should be vertical consolidation also.

When we asked you who, there was a

substantial majority in favor of one particular unspecified new organization with a minority dispersed among several existing organizations.

Now, we asked you some other questions about the details about how that agency might internally be organized in management that won't go through here. But what I drew from that was the task force seemed to feel by a substantial margin that there ought to be consolidation both horizontally and across types of insurance entity and vertically among the health care delivery system of regulatory authority.

Now, we've shown you in several different formats that are in your slides and formats of the past how this authority is organized now and including that spaghetti chart I showed you just a moment ago, with apologies that is quite a dense slide and, therefore, reproduced in your packet. This is the crispest summary that I have been able to identify of regulatory authority.

I just want to take a minute. I don't expect you to absorb the details of this now, but I just want to introduce this framework to you so you can review it at your leisure later.

The columns are different types of regulated health care to the public, different segments of the health care system. Groups of three broad categories, "Financial Intermediaries, Providers and Facilities," and then specific realizations within

those.

The rows are of two types. One are several "Different Regulatory Functions." The second -- that's the first group. The second group are several different current policy goals that regulation could be intended to pursue.

What's in the cells are the state organization responsible for regulating those specific entities, either in terms of a specific function or a specific public policy goal.

I mainly want to draw your attention to two things at this point. The first is that within each individual cell in some cases you find duplication. As for example, in the licensure of individual clinicians where there's mixed authority between the Department of Consumer Affairs, health boards, like the medical board, the nursing board, and Department for Health Services for that matter Department of Social Services, and depending upon who the clinicians work for. And even if there is duplication within a in a given cell, in almost every one of these columns there's duplication among these columns. Now, I think that has at least in the abstract two unfortunate consequences.

The first for consumers is that when you have multiple organizations responsible for regulating the same entity, the consumers often don't know who's really handling it. They don't know who to call, and they don't know who makes the decision, and in some

cases -- well, I'll stop there.

For regulatees, there's a not dissimilar almost symmetrical set of problems which is that the regulatee, depending upon your point of view, they either face an unfair and unlevel playing field, for example, a regulatee whose indemnity insurer faces a different fee structure from a regulatee in a managed care plan. If a regulatee offers a portfolio of different kinds of service, they will have to deal with a number of different regulators and, therefore, suffer duplicative set of rules and duplicative set of ways to deal with those rules.

That's a version that burdens the regulatee. A burden that proposes, I think, a malign opportunity for the regulatee. If they have a choice of regulators by making minor modifications by the way they organize themselves, then they can ask and gain assistance.

They can choose their regulator based on as a business strategy, and, therefore, when we presume in many cases would choose a more benign regulatory climate, in other words, a less stringent regulatory climate, for those reasons, I think by and large that duplication has substantial negative side effects.

Now, if you take that together with the comments you made in the Delphi, this suggests to me the following, and the comments I'm going to make hereafter are entirely my own personal impressions, and they're

meant to be conversation starters to open this up to discussion in just a moment.

The first one is that wherever possible regulation in a given column should be consolidated within a single regulator. Furthermore, my belief is that when across columns you have very similar substitutes as, for example, some indemnity insurance versus prepaid health plans or medical groups versus prepaid health plans, which was in the Loma Linda example just a moment ago, where you have to like substitutes, it strikes me as quite plausible that you should consolidate them in a single entity. So they're dealing with a common set of rules, a common set of procedures, and by contrast consumers can go to a single point of content.

Now, the question becomes how wide would you cast that net. I would suggest that, personally, I would cast that net to include at a minimum starting from the base of prepaid health plans, which is mainly but not exclusively the responsibility of the Department of Corporations now.

I would certainly consider sending that to indemnity insurance with almost as much conviction I would also mention medical groups and individual clinicians with much less conviction I would at least put a question mark after that facility. In my case, fortunately, I do not understand facility regulations to make a recommendation in that area.

Now, I have two more slides, one substantive slide, one joke slide. Just to try to give this a little bit of structure, this is my cut as what striked me as the key objective to designed goals for this new regulatory organizational structure being consolidated or not.

One which I've already been alluding to is that the regulator needs to have the authority and the philosophy to be considered as a health system as a sub system and to regulate light substitutes, not simply a particular part of the system that they have because of an artifact wall.

Second is efficiency, and by efficiency I mean this in the economic sense. The market is very efficient at -- very efficient at creating new business forms and improving cost, access, and depending upon who you believe, quality. And the regulator should -- the regulator should not impede that market evolution wherever possible to foster it as long as that evolution is consistent with public policy goals.

Fairness and rigor I've already referred to. In essence, the playing field should be level so that regulatees which for all intents and purposes are similar organizations, are subject to similar rules, and measured against similar yardsticks by a single regulator.

The encouragement of innovation I've mentioned already, in essence, the regulator should not

inadvertently stand in the way of valuable and important innovation along the lines I mentioned.

And then finally, any change that, of course, should be at a very low fiscal price and other price. The transition price should be kept low or compensated with savings thereafter.

I want to mention this and put this in your head because I very much like your comments because as we prepare an ultimate recommendation building upon the springboard I've built today, I want to know if there should be other elements besides these on this list here.

Now, my final slide, just to put all this in prospective, it's important to come up with a -- with a functional and effective regulatory organization, but it's also important to make sure that you work on the right problem. Here's an example of the regulator who worked on the wrong problem.

Depending upon your point of view, the market or either, you know, either beneficent benign producers of greater quality, lower cost, and better access where there were patient likings, but either way, the regulator should be adapted to and extremely the parts of market that are most effective and not hindering important innovations that can occur.

Okay. I'm going to put this slide back up or any other at your request, but I would like specifically now to solicit your comments both on the

criteria and on this whole concept of vertical and horizontal consolidation.

If I have any thoughts? It's a good point. Thank you, Mr. Alpert.

DR. ALPERT: Well, I would frame -- I would add to the way you framed this, actually if you leave that one up, if you eliminate the first two lines, i.e., what the regulative animal is that's the issue here. Your recommendations really apply and in the direction that we're regulating almost anything. They're all admirable, but our specific problem relates to the animal we're dealing with here, i.e., managed care. And the reason we're here is not to belabor this is people are upset. We keep asking this question, "Why are they upset?" And I think contained in that relates exactly to what you're talking about in terms of consolidating regulation to have two entities and put them into one if they lend themselves to the group.

I would frame it slightly differently. I think the animal we're dealing with that has the problem of having two separate sub animals in it headed under one category that are so different that you need to take both into account when you regulate.

I'll simply give you an example in a very small microcosm. I don't know if anybody else here is either themselves or whatever business they do regulated by more than one agency because of the desperate nature how the business is run or not. But I am a small

business owner, small corporation, and everything I do in terms of articles and corporation taxes, reporting requirements, and laws in regulations that I respond to as a small corporation are regulated by the Department of Corporations. This is in existence today. That's all.

DR. ROMERO: If I can clarify that, as a business.

DR. ALPERT: Precisely. Fiscal solvency, all of my records, all the way to pricing competitions so forth and so on. In the delivery of that business which happens to be health care there is a whole other aspect that lends itself -- I think that's our problem. I think it's the -- right now we have an all or nothing regulation; whereas, on the prima level, for instance, what I do when I practice medicine I'm regulated by a whole different entity in that practice. I'm responsible by my license in the State of California by the Department of Consumer Affairs.

Now, that actually works right now. And so here's the situation where I have -- as I'm conducting my daily activities or my business, I'm really responsible to two separate regulatory agencies for two very precisely defined and very different issues. And so in one sense as you presented initially, you know, if we have two regulating agencies dealing with one animal, we should decide whether or not that's problematic. Well, I would throw out for discussion

maybe if we had it the other way. Maybe the animal we're talking about, i.e., health care delivery, because really a health care delivery system if indeed some of these other things that Chairman Enthoven has brought out in terms of enterpriseability, and how they practice medicine and so forth and so on. There's a large trend and certainly large group of people that think that maybe that's true; that if we acknowledge quality in health care delivery and giving care is a big part of it, which I think everybody does. And we know that corporate structure is a big part of it over here. And isn't that on a much larger scale an example of kind of what I'm doing that already exists as an individual, and that just right now seems to be working.

I'm not proposing that we do that, I'm saying maybe that's a possibility. Maybe the world wouldn't end if we separated two very different parts of what managed care health delivery is and allowed, say, DOC to continue to regulate all of those corporate structures and had a medical quality oriented group, whatever it be, a newly established group, that essentially puts the consumer, the patient, at the center of the regulatory focus and how they get their care which is exactly what happens to me when I give care, and then they look at it that way, and put that there and the corporate part here and have them either regulated by -- in the same way that my practice is just divided by the job.

The other option is everybody voted -- the majority voted for a separate new agency. We weren't really given some other options as a hybrid or combination or creating and so forth, but I think that most of the problems that have resulted in creating by public demand in task force to the legislature have been on that perception of the quality side in terms of daily care, that may have been over here with the corporate structure of this whole responsibility.

DR. ROMERO: Two-fold. First, that the dichotomy of the side if I used the words business and financial rates on one side of the column and quality care regulated on the other, is that conservative?

DR. ALPERT: I don't know that that can't work. Maybe it can't work on the large side --

DR. ROMERO: Okay. Let me translate.

DR. ALPERT: Sure.

DR. ROMERO: Second is also you said you were regulated by the Department of Corporations.

DR. ALPERT: And the medical board is under the Department of Corporations -- oh, I'm sorry.

DR. ROMERO: You said corporation.

DR. ALPERT: Yes, on the business aspect.

DR. ROMERO: And in that respect if I understand you correctly, you can get corporation regulations simply as a corporate business. There's no special outcome under that. If you were Bud Alpert Shoes, Incorporated, you would get that same regulation.

DR. ALPERT: Precisely. And I have to follow a certain set of rules over here and follow a certain set of rules over here, and both are part of what I do. It's just the nature of the beast, and I think managed care is that kind of beast also.

DR. ROMERO: Thank you. Barbara?

MS. DECKER: I think this is typed to somewhat what was just said by Bud, but I want to expand it a little bit more in thinking about how some dispute resolution information has come into our resource group.

I've been concerned we've talked about it in our group about the inherent effect a regulator has on reviewing how decisions are made in a plan and how if you have a lot of potential power or implied power that you may influence how decisions are made in ways that perhaps we might not feel comfortable about except back from that, in other words, if one entity has all power, I think we might be creating some difficulties and, so I want to stress again thinking about the different activities and what's appropriate to have route together.

I'm thinking specifically in some of the information we obtained from the health plans they talked about, the Department of Corporation is looking at some of the complaints and may not even be saying it's appropriate, but the fact that the Corporation is looking at something makes the plan change how they are looking at it, and maybe that's good. Maybe it's

something the plan should have done anyway. But there's kind of an overlap and undue influence perhaps where a certain kind of judgment is kind of crossing over into a different kind of decision making process.

So I'm concerned -- I like the idea I really advocate for having as much simplicity and consolidation because I think that's something that makes sense to me if an individual wants to know where to go and how to get things done and having one source, et cetera. But I'm concerned about the variety of activities and is it appropriate to have things that are dissimilar handled by the same entity when there's a different sense of judgment that's involved.

DR. ROMERO: First of all, as many of you know, I worked for several years for the Public Utilities Commission. So I very much know where you speak, but a stray comment made by the PUC Commissioner or by me would get interpreted as the gospel by way of regulation, and sometimes very unintended effects.

But I'm trying to see how consolidation magnifies that problem or said differently, I mean, there's no checks and balances. If we have several different regulators of the same organizations, there's no checks and balances going on there. So how does, you know, my question is if you consolidate across several single regulators trying to work under DOC, how does that magnify the problem you described?

MS. DECKER: I guess I'm trying to

clarify or advocate toward the idea that regulators are looking at one set of requirements. They're trying to be sure that X, Y and Z things are done.

Now, should they also be looking at other kinds of processes, and we have clear lines of authority, clear lines of accountability, and have an entity that is responsible for insuring that the right access to provider care is available, looking at how a decision was made about medical necessity. There's a different type of expertise there that perhaps need to be clearly -- they don't need to be necessarily different entities, but clear lines of authority so that they're not undoably put in positions that are not giving authorities their rights or responsibility --

DR. ROMERO: I think what I just heard is that you're less concerned about the arrogance of power of consolidation than you are with making sure that authority is consistent with expertise, in essence, that people aren't freelancing and making decisions outside of their area of expertise in the consolidation organization. Am I hearing correctly?

MS. DECKER: I think that's accurate in that making a deliberate or even intend, like you mentioned your comment, might be looked at as an indication of where the authority is going to, someone may react to it without having sort of necessary due process that should take place before certain actions take place.

DR. ROMERO: Let me just one other minor sidebar in this context which is I didn't belabor this detail now, but the whole issue of once this task force or anybody else has settled on what kind of consolidation, if any, should occur at the status quo, and what kinds of regulator organizations should be in the responsibility of our regulator?

Then there's another detail question which is how that regulation should be organized? For example, should it be a single-appointed head like a department director or should it be a board -- we heard a bit about this in San Diego. I'm concerned not getting premature of that context, but one way that a lot of regulating organizations deal with keeping the process honest, on your last comment, is by making it a very transparent process about like a board says, and we heard from Professor Feldman in San Diego. He made a recommendation along those lines.

Now, I've been ignoring this side of the room. Anybody else? Yes.

MR. ZATKIN: It's still too short. Phil, just a few thoughts. You've laid out the regulation of the health care system which is not the same as managed care. Although, managed care consists of -- I mean pieces of the system obviously are part of managed care, but there's a reason why those elements are regulated the way they are. And I'm not trying to say it's done perfectly because it's not.

The licensure of individuals involves a very focussed effort to determine professional standards and education and individual discipline. When you deal with a facility, you're looking at a set of standards that are quite complex and relate to the facility. When you're talking about a health plan, you're talking about systems that have been placed in the plan primarily systems -- it's not a place as much as it is a set of business practices.

Now, there are common elements that have to do with quality I would agree. But when we look at the overlapse I think that we need to be careful because I think if we were to put all of this together, I would argue that we end up with the same individual functions. It might be located in the Department of Health Systems Review, but you still have people focusing on individual licensure and so on. So that's one point.

Secondly, Medi-Cal I think has a fiduciary obligation that's different from the Department of Corporations. Medi-Cal is the purchaser. The Department of Corporations sets basic standards for doing business. Medi-Cal has a higher obligation as a purchaser on behalf of the beneficiaries. And this issue of whether we can get rid of Medi-Cal standards and have just DOC I think is a very complicated one, and I personally would be concerned about eliminating a fiduciary obligation --

DR. ROMERO: First, I'm going to ask you

to amplify "get rid of Medi-Cal."

MR. ZATKIN: I thought you said where there's an overlap you would like to consolidate. And that's where --

DR. ROMERO: Yeah, that was a broad comment. My personal view, in my personal view, the duties of a purchaser are substantially different from the duties of a regulator. Personally, if I were king, I'd separate the organizations. So that's -- that particular element of consolidation I don't agree with.

MR. ZATKIN: And third, indemnity insurance is fundamentally different from HMOs. There is an area where there is some overlap benefits and solvency, but even the solvency standards are different because HMOs have less liquid assets, and their ability to provide main services. So I think we need -- I'm not saying there isn't some consolidation that can occur, but I think we need to be very careful in how we go about doing this. And I think we ought to be focused on managed care as opposed to all of the constituent elements.

DR. ROMERO: Thank you. Ron Williams?

MR. WILLIAMS: Yes. I would echo slightly different points. One thing I cannot suggest is that the survey that we took provides some very information baseline discussions --

DR. ROMERO: The Delphi article.

MR. WILLIAMS: But I think we were also

fairly early in our process. I think it would also be interesting to readminister either that or a version better educating some of the issues in the processes.

The second thing is when you look at the role of the agencies, I think we're looking at to some degree from the government avenue as opposed to from the legislation that created that solve a problem from the consumer point of view individual.

And I think looking at it in that way causes us too high a level that we need to go to the nature of each organization and have more clarity about that and look at the focus and accountability of even I think an example is in the figure that showed all the state agencies that oversees the health care regulation, it says State Health Care Oversight for Managed Care.

Some of those have a central mission that really isn't related to managed care, and managed care is evolving. And there may be opportunities to streamline, and I'll pick just a couple. The Department of Industrial Relations division workers' compensation. Their central mission is that an injured worker really receives both the right level of compensation for their injuries and the right level of care. So it's a very different kind of concern. There certainly are opportunities for streamlining. I think that what that leads me --

DR. ROMERO: Actually, if I can just interrupt. If I use my dichotomy in terms of regulator

for a second, I would interpret the way you summarized the air of responsibility is really more of a purchaser's role than a regulator's role. You agree with that?

MR. WILLIAMS: Yes, it's there in purposes of role and also for Medicare I agree with that. I think the conclusion that leads me to that, it's a challenge to deal with such an enormous organization from the top down because top down the similarities are overwhelming. It's all dealing with people. It's all dealing with health, and you can build a case for a lot of economics, but conglomerates don't work for business. They don't work in government because we don't focus. We don't have the accountability what we are established here to do whether it's doing the workers' compensation, dealing with the licensed, you know, whatever --

UNIDENTIFIED SPEAKER: Could you speak up please?

MR. WILLIAMS: Yes, what that leads me to is I believe that a streamlining approach, as it looks, very focused activities looks to be objective of each organizations how can we streamline to the extent to streamlining you kind of roll functions up. Then you're left with the inevitable answer that something that makes sense.

What I'm getting at, not so much as global, this is not health care and managed care, but

getting at, all of these groups are visiting doctors' offices and looking at charts, and is there a way to streamline that process so that each mandatory function can be accomplished?

DR. ROMERO: Thank you. Let me just make a brief comment that Ron's comment stimulates. Unfortunately we've lost the bulb in our overhead projector thanks to our host. So I can't show this to you at the moment, but I want to draw your attention to a chart I put up very briefly. It's a major -- Figure 4 California Health Care, the current state regulatory jurisdiction.

The rows in that matrix -- I'm sorry. The rows in the matrix were an attempt at an early and admittedly very top level function of breakdown in the spirit of your comment on it, and I want to draw your attention to this -- I want to draw your attention to this because if at a later point you have comments about its accuracy or comments about a greater level of detail that you think might be necessary to hear comments on, I would very much like to hear them. Because at the moment this is the -- this is the most -- this is the crispest summary of my statement of the functional responsibilities of different organizations. Okay. Thank you.

MS. BOWNE: Actually, I was rather struck that even this is a complex chart, it has the clarity to it. And the one thing that I was noticing that I was

pleased with is the fact that for the most with one notable exception, the responsibility for the various regulatory functions are linked to enforcement, and I think that that's appropriate. In other words, if they identify the problem, they have a way of either yanking a license or putting in a fine to correct the problem.

The exception is when you get over into medical groups, and for the most part where they come back to the corporations when you get into enforcement that says market through the plans. And I think that that's a potential area here where we've heard discussions before about the kinds of resolution that go on between individual patient and an individual physician within the medical group and health plan and the health plans holding the medical groups accountability.

And I think the kinds of things you're giving the facilities which are in the current time for the most part very different than those that we look for in health plans or insurance or medical groups. Probably just as well they are separate; however, when we take in the incidents of where, and I suspect we will see more of this in the future, with the provider service organizations and Medicare risk, and what we're seeing now the applications to the Department of Corporations for various particularly larger institutions will probably change over time to contract directly. There is more room for overlap, and it's my

understanding that when they want to become the direct provider and in effect insure they go through the Department of Corporations; is that correct?

DR. ROMERO: The assistant director is in the audience, so Gary I invite you to correct me if I misstate this, but my understanding is that if they -- let me see if I got this right -- an organization can choose to bear risks and apply for a limited Knox-Keene license, but they have to be affiliated with a full Knox-Keene licensee.

MS. BOWNE: I think, for instance, let's say we were partners where they normally would be considered as a medical group, but now they can apply to the Department of Corporation --

DR. ROMERO: They can now also apply for a full Knox-Keene license.

MS. BOWNE: Yes.

DR. ROMERO: All right. Yes?

MR. LEE: They have a limited Knox-Keene --

MS. BOWNE: Limited, they have a limited Knox-Keene license.

MR. LEE: They still need to have a license contract through a fully licensed Knox-Keene plan.

DR. ROMERO: That's what I said, but it's also possible, I presume, if you're willing to accept the financial solvency, and other departments can also

apply for full licenses, right. That's a business decision made by the organization.

MS. BOWNE: Anyway, to sum up the whole thoughts here is rather than thinking it's too complex and needs more consolidation, I think you demonstrated here that there are some pretty clear lines of responsibility and accountability by function. So I would say, you know, with some minor tweaking, it actually looks better.

DR. ROMERO: Okay. Just -- let's just pause here a second and just note that thus far we've heard two alternative hypotheses, and I just want to get them on the table so people know what they are.

One is to some degree of consolidation across multiple regulatees and in our discussions I said I'm not prepared to make that direct statement.

The other is in essence, preserve the current system in, you know, process improvement, and then either accept that the process improved it or only consider reorganization after it's improved. That's my translation of your comments. Is that a fair summary?

MR. WILLIAMS: Just repeat it one more time.

DR. ROMERO: Okay. Alternative option B is status quo with process improvements upon the completion of a practice improvement. That's the time where we will consider any reorganization.

MR. WILLIAMS: I said it just a little

bit different which is start with the mission and focus of each entity and have an enriched understanding and view of what that focus and mission is.

To answer the streamlining questions to some degree is laid out here in opportunities for processing improvement, and then balance that against the economic commission. Many of these organizations have fundamentally different organizations and trying to aggregate them, we run the risk of losing a focus on the original mission.

DR. ROMERO: Bud?

DR. ALPERT: Actually, what Ron just said is what I wanted to. And that's losing focus of the original issue and for -- I think I may be confused, I may not. If you say process improvements, I assume what you're saying is an improvement to address what is perceived as a significant problem and that is --

DR. ROMERO: I use a bit of a business chart. Let me give you an example --

DR. ALPERT: And that's fine, but it's not saying that everything -- because everything fits nicely and has a box with a name in here that everything's fine.

I guess what I'm saying is that process improvement phrase is not -- should be addressing why we exist. It's not an insignificant process improvement. It may only require one little glitch within this framework -- change within the framework which would be

easy and simple I think if that's possible.

DR. ROMERO: And again I'm not trying to drive us to a decision, I'm trying to articulate the options.

DR. ALPERT: Right.

DR. ROMERO: In my ending phrase like process improvement, I used a bit of language how you trivialize the challenge to civil reaction, and that's a fair point. Sorry. Michael?

DR. KARPF: I think one of the problems I'm having is we seem to be driven by care. We're taking a look at what existed or what exists and trying to figure out how we can fix it. I'm not sure that the problems that we're being asked to address, in fact, have been addressed by issues of the past. So I am concerned that maybe we're getting ahead of ourselves. Maybe what we need to do is to find the issues where the problems exist, and then see if some of them are being addressed and some of them aren't being addressed.

As an example, I've listened to people give testimony. We've discussed that the issues seem to me, they seem to fall into several categories. They seem to fall into whether beneficiaries or users of the health care system understand what they're entitled to, and that falls into the issue of design of benefits. And we may need to look at that a bit differently than we've looked at it in the past.

They fall into the issues of what they

are entitled to, and that is appropriate. And that goes to the issue of quality, whether it's quality of providers, quality of institutions, quality of process. And that may not have been addressed appropriately in the past, and it falls into the issue of availability. And that's the issue of grievance and distribution of providers.

And I'm not sure that looking to the past is going to answer those questions, so maybe what we need to find are really the problems and then see if there's a mechanism of answering those issues.

DR. ROMERO: This is why I said at the outset this is, you know, who regulates is extremely entirely interdependent with what the policy philosophy is of the regulations we're supposed to implement. You just gave a couple of very good examples of that.

Bill, did you have a comment?

MS. SINGH: Dr. Romero, before we begin, we've had a couple of comments from members of the audience. Task force members, when we use the mics, please almost eat them. If you speak very closely into them and attempt to project your voice, we can ensure that the members of the public can here, but you really need to get right on top of it in order for them to function fully. Thank you very much.

DR. ROMERO: Ellen?

MS. SEVERONI: I wanted to go back. I wanted to move away from the little boxes, Phil, and I

wanted to go back to the slide that has what I think would be described as the core principles.

DR. ROMERO: With any luck I'll be able to project it in a moment.

MS. SEVERONI: Okay. Great. And the reason I'd like to go back to that, if you don't mind, is, Steve, you spent a lot of time talking to the public about the values and principals and what we want in the systems. And I see, I think, the important data missing here and that would be accountability.

Now, it's been mentioned several times by my colleagues here. By accountability, what I would translate that to mean is that I myself or any of my family members wouldn't know who to call. And so that if we're going to design a system that's going to regulate, I want to know that one of the core values being put in place is going to be accountability.

And one of the issues here is knowing as well how strongly the public feels about their providers. I think that this is also going to have to be a system that is accountable to the providers as well where that doesn't at least split us. So that would be important to me.

And the second thing that I noticed whenever we talk about regulating or somehow taking care of the large groups of people, that it seems that we forget that those are the very people who know probably how to innovate the system probably better than anybody

else.

So when we talk about encouraging innovation, I would like to add as member or beneficiary, I would like to see us regulate a way that innovations are driven by those who are using the system, not necessarily the people that are invested in designing the body that regulates it.

DR. ROMERO: On that, my example of this has always been GM who in the late 1980s never had a customer who told him how to design a car. Is that what we're talking about in essence?

MS. SEVERONI: One of those kinds of things so when we look at the designs, we're saying, "Let's look for something new." One of the things that we need to fill in is a system that improves itself based on the consumers that use it. So that might mean things like advisory bodies and all sorts of -- I don't want to get into all of those boxes, but I agree in the principle innovation would be member driven since we're all members of organizations, that we would have to design ways to keep that member voice included.

DR. ROMERO: Ellen, bear with me. One quick follow-up, Ellen, on accountability, and this is a box question, and I apologize. But you have an off-the-cuff view as to the importance of consumers, patients, having a single phone call if they have grievances? I mean is it important -- is it important that a single organization be responsible for regulating

that or not?

MS. SEVERONI: I can't give you an off-the-cuff answer. What I can tell you when you ask me that question is that what I've heard most often is that people just simply are somewhere stuck in the system and rather than make the grievance, they want to know how to talk to the person that's going to help them get through, get to the next step. That's my experience.

DR. ROMERO: Okay. Ellen, I'm sorry. I promised Bruce.

DR. SPURLOCK: I think that people have talked earlier about us noting the original problem, and I want to bring up a point that I think there's a myth potentially in this whole discussion of oversight and regulatory change and regulatory structure change.

When Mary O'Sullivan addressed us at the very first meeting, she talked about restoring the public trust. I think it's a myth that changing the regulatory structure will restore the public trust. I think that's a fundamental issue we need to accept.

The only way I feel to restore the public's trust are actions that people can depend upon on an individual basis day by day. That's one point that I want to say that we're not really going to address the fundamental problem that many people are looking for with this task force with this subject.

DR. ROMERO: Can you just hold for a

second? I would just like to address that. Would anybody disagree with the proposition that regulatory organization will play mostly a minor part in the restoring of public trust? Does anybody think that's more important than that?

MR. LEE: Say that again.

DR. ROMERO: I translated Bruce's point that the proposition is fixing or changing the way we organize state regulation will have a mostly minor -- play a mostly minor role in improving public trust in the health care system. Does anybody disagree with that?

DR. ALPERT: I do.

DR. ROMERO: You do.

DR. ALPERT: I think potentially it depends on what you do. If you quite clearly put the individual citizen, consumer, everything Ellen said would resinate at the center the object of that regulatory agency, it simply has to do with the quality of health care delivery. Then I think that the potential may be there in fact. Each --

DR. ROMERO: Sorry. Okay. Bruce?

DR. SPURLOCK: Having said my previous statement, I do want to make one observation. I think the fact we came here to talk about managed care, and if you look at your boxes under quality of care there's nothing on indemnity insurance. Actually, I think that's inaccurate. It is something you know that's

worthwhile because we're talking about a new structure here. And in reality my experience that indemnity insurance is indirect in the marketplace and reputation in what we call indirect measure from the driver's of that issue.

But more importantly, I can only agree with what Dr. Karpf said. I think we need a new regulatory language because I think our regulatory thinking and the regulatory structure involved in time when we didn't have such a tight relationship as finance and delivered health care. We weren't being linked I think in a regulatory framework from that standpoint, new reality talks about new accountability.

What I just mentioned with indemnity insurance, we had very loose notes of quality it was based on reputation, what was the best medical center, which was the best physician entity. We now have performance measures and increasing levels of accountability, different levels in the system that are new, and I think if you look at a regulatory structure from that framework and also from the framework that we're married at the hip with cost in effecting this equality. I mean there's no way to separate those three out. And as long as we try to look at those different regulatory agencies with different regulatory functions from the old language, I think we're bound to fail.

So when we look forward and look at the details because that's where we delve -- we delve into

the detail success of our efforts to restructure really at the detail level we need to remember that those things are changed now.

DR. ROMERO: Allen Zaremberg. Get close.

MR. ZAREMBERG: Thank you. I start this with, and I think I'm sort of finding out that my question about four people ago was what was really the issue as to why people want to change the regulatory structure. Is it restoration of public trust? Is it they're not following the law? And is it they're not following the law because they don't have adequate resources or is it the law is inadequate?

And even though we had a survey about people on the task force indicating why they want to go -- no, where they want to go, they don't say why.

DR. ROMERO: We didn't ask them.

MR. ZAREMBERG: And it's very, very difficult for me to say I appreciate your concern, and I think to satisfy your goal the best thing we can do is to do this, and you know add my two cents worth or my expertise that I've had and to be able to say you want to do this. That's your goal. I think the best thing is to do this, for example, let me give you a couple of examples.

I think restoration of public trust, why is that? And when the commissioner was here, he talked about his increase in funding, and when we asked people what are you uncomfortable with or what do you think

they're not doing, did the increase in funding which was a substantial increase that the legislature directed, does that satisfy some of the concerns that some of the task force members have? I don't know that. It would be helpful to know what people are concerned about. And like I said, there's a law out there that regulates health plans, is it not being followed because there's inadequate resources or because people aren't following the law?

In terms of there needs to be an ability to have a place where you can go to make your consumer complaints. I'm not sure that's a question of the regulatory body, itself, or the establishing a mechanism for consumer complaints that clearly the people understand; whether it be the office of health care consumer complaints and that can be in the Department of Corporations or the department of health service. It can be anywhere as long as people are aware of the standard, and it's consistent forever. And something that's easy for people to understand, that's as much marketing.

Peter's point about public trust, it's -- I think it's a question of why have people, you know, why they feel they're not regulated properly or is it a question, not a very simplistic question, but it very well may be, that you're not satisfied with the securities attorney overseeing the health care industry. And I'm not sure how securities people would feel if

they had a health care person overseeing the securities industry, which is a good way to put it.

If that was a concern, and if financial resources have been added to help take care of it, and, you know, in terms of that, then that is a different one. That approach is mainly spun off in the same agency with a separate department. And is that, you know, I'm not sure what I'm trying to gather, I'm trying to find out exactly what people's goals are.

And I, you know, if that were the goals, I wouldn't necessarily object to people saying, "Well, we want a board." Well, I would object for ten different reasons just because it's just bad government, and it's just inefficient. But if I can know that whether the discussion today is to help flush that out or if we can question the individual members of the task force so we know exactly what goal they're trying to achieve, what issue they're trying to fix, if it's broken, then hopefully we can help draft something that's a solution that it's a consensus.

DR. ROMERO: Two quick comments. You've heard me several times say that this is in some sense premature, but I think ultimately your recommendations is more appropriate once we have policy substance to provide contact.

I'm doing this now, this is an artifact of our older scheduling decision. In our original Delphi because of that schedule we asked the questions I

have already told you about, a few more detailed ones, the ones I will mention in a moment.

We did not ask what do you think the principal problems are that couldn't be solved by an organization, and I think if we go out and capture the task force's opinions in a structured way, like Delphi again, we could certainly do that.

Secondly, just the factual announcement I think you made, Allan, which is about the corporations' budget. Unfortunately I don't have the technology to show this to you, but in our Delphi we asked the following question, "The DOC budget was $8.9 million; it was just increased by 73 percent or $6.5 million. With this amount, the DOC is expected to monitor HMOs with $34 billion in revenues. Do you think the budget: is about right? Should double? Should triple? Should be based on a ratio that varies as a proportion to total the HMO revenues?"

I think a comment of probably is even more important than specific answers, and I'll show you.

What I got out of this was in essence that the -- being the relative endorsement of the specific dollar amount was pretty tentative because a lot of the task force members thought this was just too detailed for collective members.

You want to comment?

MR. ZAREMBERG: I guess the question would be it would be helpful to have the department

explain it because in terms of regulating managed care when you say, "Should it be a function of the enrollees or the function of revenues?" Is that more merely a function of how much they handle consumer complaints in that particular division in terms of regulatory oversights as to what their other responsibilities may be, improving mergers, other things like that. Is that a function of revenues? It may not be a function of revenues. It may not have no relation at all, although, I think enrollees may have a clear relationship to maybe an officer of the court, the resource issues director of consumer complaints, but in terms of all their other regulatory responsibilities that may or may not have a nexus now. And I honestly don't know, and maybe everybody else around the table knows, but I don't.

DR. ROMERO: Let me just propose on this issue -- okay, Keith, you want to make a brief comment?

MR. BISHOP: I can explain it.

DR. ROMERO: Go ahead.

MR. BISHOP: Basically the augmentation was not based on any arbitrary percentage of revenues, number of enrollees. The augmentation that we did was over a period of several months, we looked at the performance levels that we expected either sometimes a performance level was set by statute, for example, we're required to approve or disapprove a notice of modification within 20 days. Others were internal performance standards. It's my goal that we have no

complaints over 60 days old. We have medical surveys within the years.

So what we did, we went through everything we had to do, and then we evaluated whether or not we were doing it in a timely fashion. And then if we weren't, what would it take to do that. And that yielded, basically within the demand how many attorneys, how many examiners, how many health care analysts, it would take to achieve that performance level and turn the crank and out came the budget augmentation that we submitted to the legislature.

So it wasn't a reflection at all of the revenues of the health plan industry or the number of enrollees. It was workload performance evaluation.

DR. ROMERO: Okay. Just secondary question, Keith. Since roughly half the task force members thought in essence your funding should be variable based on some proxy for workload like enrollees or health plan revenues, if you could just briefly comment on whether if there is a similar proxy. Is there a suitable proxy?

MR. BISHOP: I think it's too complicated because what we have to do is break out various components of the workload. What we've seen, for example, we started a 1-800 number in 1995, and we've -- I anticipate a certain level of phone calls after we enforced the law regarding notification, and somehow we saw that number of phone calls double.

So what we do is break out that component, evaluate how many people it takes to answer the phones, how many people it takes to process the complaints, there's so many phones in here, there's so many complaints we get which translates so many people that handle those complaints. And I'm not sure that a gross function like the total number of enrollees is a very good proxy for the microanalysis.

DR. ROMERO: Thank you. We're just about out of time, but, Peter, I think you had a comment.

MR. LEE: Couple of comments, a couple on the big picture of the question how many on the picture --

DR. ROMERO: Peter, would you get closer to the microphone.

MR. LEE: The first I wanted to echo a number of comments on the need to have on this list of what needs to happen, and that is accountability. And that is -- a couple of it is trust in the regulator. And I think that's an important factor that really has been missing, but it's also accounting for liable, and I would like to process what we're talking about saying the functions that we're doing the specifics first, oversight resolution processing plan, financial incentives, because that's really where people have trust, and the regulators is second to your question. The important second to your question, so I think we're going about this right now in terms of coming back

around to talk about the regulator after we've talked more about what we're moving into, so I appreciate that --

DR. ROMERO: Peter, just a quick interruption on that and Ellen Severoni made a similar point in your paper which I think has been distributed? Right, and I consider it a pretty incomplete draft. There's a longer list of criteria that I showed on my slide including one that looks a lot more like accountability in the work fairness. But I agree completely by definition if people don't feel the regulators are being attentive to their interest to the providers or consumers, then it's not accountability. Sorry. Alain, go ahead.

CHAIRMAN ENTHOVEN: No.

DR. ROMERO: Go ahead.

MR. LEE: The other issue about accessibility part of the things that I structured by the chart is, different charts is that, yes, they're confusing for providers, but they really are very confusing for consumers. Consumers don't know where they fit, and I think one of the problems with that is -- and this is where we look at the interface between making, for instance, accessible potentially what number, et cetera.

Yes, I agree, absolutely, with -- I think Ellen made the point it doesn't need to be one agency, it could be a shared place, but people right now are

very confused. They don't know if they're in something that's regulated by X agency versus Y agency. And for the consumer, the differences are really quite hazy. And that's a specific issue I wanted to both agree and disagree with some of the things that Steve said in terms of functions. There are certain functions that do farm out separately, such as individual practitioners, facilities.

The place where I got notice of foreshadowing we're discussing later and less clear is plans the groups that systems appear delivery in place aren't just health plans anymore, they are also medical groups. And they may not have full risk like health plans do, but they are systems through which from the consumer's perspective they can find hurdles or systems they need to navigate, and what that means from the consumer perspective, they see what in essence is a mini plank. They may not have full capitation passed down the stream, but those consumers don't get full risk capitation anyway.

And that's where I think one of the sort of overlapping points similarly I agree that in many cases indemnity is different from HMOs, but there's so many shades of gray now in terms of points of service under PPOs, and that's another we need to look closely at in terms of what are the similarities and differences and what that means on ground level for consumer access and then at the higher levels of monetary oversight.

DR. ROMERO: Just as a process check, we're about out of time, and I think Allan, Mark Hiepler, was there anybody else that wanted to comment on the chart? Alain?

CHAIRMAN ENTHOVEN: Well, this is coming back to what Al Zaremberg was saying. First, I think I do agree with everybody that the arrangement of the regulatory boxes and their names at the high level is not really the important -- that's secondary important. The important thing is what actually happens down on the ground where the regulators actually interact with the regulated and with the general public.

But a couple of questions have been in my mind that I've tried to sort out as to their importance. One is should there be a health care person with extensive background in health care in charge of inventory regulatory agency, and it does seem to be one thing about law enforcement is that there have to be priorities.

It's like I noticed that driving up here this morning for the substantial part of the time I was driving over 70 miles an hour, and that was just right in there with the rest of the traffic. And the highway patrol wasn't doing anything about it because it was early in the morning on a summer day. If I was going at that speed on a foggy wet day, I'm sure even at a lower speed, they would have come after me because they understand something about good law enforcement is not

just nailing people for technical violations, but it's somehow done in light of the larger purposes. We're trying to have safety benefit and so forth.

So I do think it's important that we have some sense of priorities as to which laws need to be enforced with higher priorities since we do have limiting time. The other is -- has to do with simplifying lines of recording, and with the whole question of coordination of delivery system. We're going to need to see a lot of hospitals close in this state in the next ten years. We have too many hospitals and too many hospital beds, and too many hospitals and too many beds are bad for your health and bad for your pocketbook that if we had better quality, if care was consolidated to fewer hospitals and also better economy.

But you think of the problem of closing a hospital in this regulated world if it's participating in the, you know, it's regulated, it's contracting with a dozen different health plans. Then they're going to have to deal with the facilities' regulators and that's going to have to do with things like do they have the right numbers with the right experience and so forth. And they're also going to have to deal with the Department of Corporations through the health plans because they're going to close each health plan and have to file a notice of change. And that DOC will look at that, and I could just see a lot of desirable mergers getting somehow caught in the crossfire here. And

somebody needs to be looking through that and saying is this a good, overall good thing for the health and safety of California economy -- of California or not.

And so these -- I think these do need to be coordinated or to take another is with personnel licensure. I think we're moving into the era -- out of the era of the individual practitioner and much more with complex modern medical care. You need team approaches, and in many cases, some members of the team are not going to be M.D.s.

I recall hearing Gail Warden who's president of the Henry Ford Hospital in Detroit which is kind of premiere of all these specialty group practice there saying, "We violate the medical practice laws of Michigan almost every day." And if anyone wants to come after that for us, we have data and they don't. But, you know, the increased use of paramedicals and technicians and so forth, and the issues are not so much -- like I was discussing this once in the presence of the a professor for the University of Oregon who said, "Oh, yeah, we have the single best decatheterizations done by technicians," and I could imagine the medical board looking at that and saying, oh, you know, from their individual practitioner perspective saying, "this is dangerous to people's health even though there's no data to support that." And you have to bring in the perspective of the organized systems, supervision of the training of

people, delegation of tasks and so forth. And so I do see a need for coordinated approaches to these issues. I mean the table that we were shown looks very neat as Becky pointed out because clean lines that prepaid health plans, it's all DOC licensure. It's all -- well, that gets it across, but what I'm thinking is that a hospital that's both part of the health plan system that gets regulated by DOC, and it's a hospital. I just think we need to be thinking about the -- how we make sure those perspectives get coordinated.

DR. ROMERO: Alain, just a procedural note. I believe that -- I believe the next item on the schedule is going to be a presentation by Professor Schauffler, and I would just like to solicit your decision about whether to continue this discussion a little longer with Dr. Schauffler's permission or to truncate it now because we're past our allotted time.

CHAIRMAN ENTHOVEN: There's a couple of people -- should we pick out those who didn't participate? Okay.

MR. HIEPLER: Just one quick one. I think the focus again as to why we're all here starts with the consumer complaint and regulation regarding that, and so one comment, if you looked at the simple fee-for-service older system, I can get rid of my problem by going to what I perceive was the source of my problem, my physician. I could switch. If I didn't like my insurance company, I could switch. And I think

from the consumer standpoint we have to look at regulation as the last effort, not a 1-800 number to call for all your problems. Because we need to incent-ize the people from -- the receiver of the services and the giver of the services to resolve the problem before we create another bureaucracy who has the least and smallest incentive to solve the problem and is incapable of doing it.

So if we look at regulation for consumers' sake, we need to give the overlap, and we really want to have it exist to begin with and to the degree we can, you know, with report cards, with all kinds of accreditations things help those companies who are doing a good job with solving their own problems and allowing the consumer to go to the heart and source of their problem as opposed to calling into the 800 number and never dealing directly with their medical group, never dealing with their doctor. It's the least efficient way to solve it. And then you bring in the whole idea if none of those work, then they go see a lawyer, and we get more inefficient.

So we're looking at regulation. We need to look at how to effectively get the consumer involved in resolving their own disputes so they don't have to call a 1-800 number, and that's the type of focus I think we need to look at when we're trying to design a plan instead of just creating a hundred new 1-800 numbers for people who call the Department of

Corporations. They could never have enough people to handle all those, and people will go to them first if they realize there isn't an internal mechanism for the HMOs or even the insurance companies to help solve their own problems and incentive to do it. Because I know many of them are happy when a patient doesn't call them and they just call a 1-800 number because then there's a delay in even needing to look into this.

CHAIRMAN ENTHOVEN: All right. That's a very good point, Mark. To some extent Peter Lee and Barbara Decker are working on that dispute resolution process; although, I think your point is even more than that.

Is there another -- yes, Clark?

MR. KERR: Just in terms of time, I have two quick points. One is I thought that Bud had a good distinction between the business side and the quality side. And I think, in my mind, it makes a lot of sense to think on the business side, the licensure or the indications of those types of things that you may have different organizations based on who you're dealing with. But I'm not all convinced that you should have more than one organization dealing with the quality of care side because that's really the side that gets to the public. And that's really the side that perhaps most of the concern to them. And they're dealing with the whole quality of care. They're not just dealing with the health care. They're dealing with the doctor.

They're dealing with the medical group. They're dealing with the professional hospital. So I really think it makes a lot of sense to have one group oversee everything that the patient sees, and maybe the business side is separate, so that's one point we can discuss.

Just to make things hot so we don't have time to discuss it again, but very important, I'm wondering if we should also, as a regulatory issue, establish minimum standards of performance to offer health care in the state of California.

If you drive up to the gas station anywhere in California your car is guaranteed to have at least 87 octane gas in your car. But if you go and seek health care service, and it's your life or the life of your loved one is at stake, you have no guarantee that you're getting 87 octane health care. So maybe we should discuss that.

CHAIRMAN ENTHOVEN: Okay. Thank you, Clark.

MS. BOWNE: Excuse me. I just don't think I can let that pass. I think that there is licensure of facilities and licensure of professionals and licensure of health plans, and they are very defined, fairly significant, standards that each of these entities have to meet. And to say that there aren't any standards, I think is slightly inaccurate.

MR. KERR: I'm talking about in terms of performance. Octane is performance per se. I'm talking

about the actual outcome. I'm talking about safety issues, and these are not really covered I don't think at this point. I might be moving to get some experts to come in. But I'll just use an example here.

In the United States every day in terms of adverse events, these are deaths from things that happened to people within the health care systems as opposed to when they went in them. These are the infections they pick up in hospitals. These are the falls they have in hospitals. These are the adverse drug reactions they have from medicine prescribed. It's the equivalent of one or two jumbo jets crashing every single day in this country. I wonder what kind of outcry there would be in this country if the FAA or the National Transportation Agency if one or two jumbo jets were crashing every day. Would they be happy? I don't think so.

MS. BOWNE: And I would submit to you that there is a system that requires hospitals to document and take action on those incidents.

CHAIRMAN ENTHOVEN: Alas, Rebecca, that doesn't prevent the incidents. The incidents go on, but you're right -- I mean, we have lots of regulations and standards, but --

DR. ALPERT: Well, I just wanted to kind of question Allan Zaremberg before because I thought that was excellent that sort of framed the whole thing.

The answer is the -- we're here because

of this massive paradigm shift in our health care delivery. It used to be all the responsibility and all the authority was in one doctor-patient relationship. It is well traced out in paper that Alain Enthoven provided us by Professor Havighurst, which I thought was wonderful. If you haven't read it yet, I certainly would recommend it to everybody about that paradigm shift going through first the hospitals and then physicians who work for the hospitals and that sort of matter. They have a bigger enterprise practicing medical care. And now we have lots of larger enterprises practicing medical care.

That paradigm shift of responsibility and authority of giving somebody care from one physician to large groups of institutions has produced the outcry that has got us here because we haven't reconciled the whole thing is now to an even larger level.

With regard to what Mark Hiepler just said, and I think Chairman Enthoven will agree, was talking about more in terms of not having a 1-800 number because if it's all taken care of internally by the self-regulation, that is also traced in the one-way to do -- that is also traced in Professor Havighurst's article on this, and I don't know if you're going to talk about that later or not.

MR. ZAREMBERG: Just to clarify the question, Alain, just so I understand it and trying to gather some information between now and the next

meeting. Are you suggesting, maybe such on a personal view, that we should take a look at having one entity that determines how many hospital beds there are, how many specialists there are, and coordinate that with the type of health care delivery system --

DR. ALPERT: Not at all.

MR. ZAREMBERG: No, I'm asking Alain because he talked about that.

CHAIRMAN ENTHOVEN: That sounds like the worst possible idea.

MR. ZAREMBERG: Because you referenced those things, and I just want to clarify that's not the direction anybody wants to go.

CHAIRMAN ENTHOVEN: No, no, but we're having -- you have --

MR. ZAREMBERG: That's all you have to say is no.

CHAIRMAN ENTHOVEN: No, all these entities are regulated with respect to health and safety standards, all these other standards, and I'm just trying to get at the idea that I think we need to look at the need for some coordination. You know, it's like these charts that we've seen where all these different lines are feeding into the hospital directly or indirectly and reporting directly in DHS, indirectly to DOC.

MR. ZAREMBERG: It wasn't a proposal.

CHAIRMAN ENTHOVEN: Okay. All right.

Well, I'm sure we're going to come back to this. I think we all need to reflect on this. We may have several variations of this. I really appreciate the good discussion we've had on this.

I propose now that we move on to Dr. Helen Schauffler who is going to give us a report on the survey. Dr. Schauffler?

MS. SINGH: I just wanted to announce there are a limited amount of copies of the slide materials on the back table.

CHAIRMAN ENTHOVEN: Also, we have speaker cards on the back table, and the way that I will call on people will be on the basis of the speaker cards, and we will call people. Please give the cards to Terry who is standing by the table with her hand up, and we will call on people in the order that she brings to me the speaker cards.

THE REPORTER: Can we go off the record for a minute? I need to change the paper.

CHAIRMAN ENTHOVEN: Okay. We'll take a short break for the court reporter to replenish her need for more paper.

(Brief recess.)

CHAIRMAN ENTHOVEN: Okay. We'll call the meeting back to order and Professor Schauffler will talk to us about the state of the survey.

DR. SCHAUFFLER: Thank you. Can people hear me? Okay. First of all, I'd like to thank all the

task force members who participated and helped in developing the public survey. In particular, I'd like to thank Phil Romero and Hattie Skubik, Alain Enthoven and Clark Kerr, Peter Lee, Ron Williams and his research director Richard Weiss, Maryann O'Sullivan, and Jeanne Finberg who remained involved throughout the entire process from beginning to end and helping to develop the survey, so thank you very much for your input.

I'd also like to thank Mark Smith of California Health Care Foundation and Joel Croker from the Friendly Hills Foundation who both made generous grants to help support the public survey which made us -- enabled us to expand our staple sizes significantly so we were able to make much more accurate estimates about the prevalence of different problems in the California population.

And I also just briefly want to remind task force and the audience of the goal of the survey which is to conduct a scientifically valid survey of mature Californians to document the prevalence of the various problems consumers are experiencing with their health insurance and their health plans in California and to get gain of a much better understanding of the types of problems that are being experienced, their severity, and the ability of consumers to resolve their problems successfully within the system.

You have a handout in your packet, task force members, with a brief summary of where we are on

the survey, and I just want to quickly go over that with you and answer any questions that you have.

This is a computer-assisted telephone interview survey. We were doing random digit dialing of the population and the average length of the survey will be 25 minutes to complete. We have three different samples that we'll be analyzing as part of this survey.

The first is a general sample of 1200 insured Californians who have lived in this state for 12 months or longer and are over the age of 18 years.

The second sample is a specific sample of people who indicate they are either dissatisfied or very satisfied with their current health insurance or health plan and/or people who indicate that they have had a specific problem with their health plan or health insurance in the last 12 months.

So we'll be sampling approximately 1200 of these individuals, and we'll also be if an individual is responsible for managing the care of a family member who lives in their household, such as a child or any relation of those in their household or an adult, and they're directly responsible for overseeing that person's health care, and that individual has had problems with the health plan or is dissatisfied -- or the respondent is dissatisfied with the care that that family member has gotten; they will also qualify to be a respondent in this survey so that we will pick up experiences for dependents who might be too young to

qualify for the survey as well as elderly people who have someone else in the family managing their care.

And then finally we'll have a sample of approximately 500 insured Californians who are frequent users of the health care system and have a high level of contact with the health care system, and those individuals will qualify on the basis of having been hospitalized in the last year or having visited a physician five or more times in the last year.

We have gone through a lengthy, but I think quite productive process in developing the survey. I interviewed 11 task force members who indicated they were interested in participating in this survey. And 13 members of a National Technical Advisory Group, experts in survey researching managed care groups across the country to identify existing surveys and possible questions to include in our public survey.

And the first draft in fact was inclusive of nearly all of the questions suggested by those contacts. Understanding of the first draft would be way too long to provide the task force members and our other reviewers what was sort of a comprehensive base they could select the priorities for this task force survey.

Copies of first draft were sent to all of the interested task force members and members of our advisory group. And reviewers were asked to identify certain areas and questions to cut by 40 to 50 percent this first draft and to identify areas that they felt

were missing from the first draft but should be included in the survey.

Based on both written and verbal comments that we received from ten task force members and advisory group members, where there was consensus to cut specific questions or revise specific questions, those were made. And where there was not consensus, Chairman and Vice Chair, Alain Enthoven and Clark Kerr, that with Hattie Skubik and Sara Singer and me to review the comments that we had received and to make what were really very difficult decisions about what to keep in the second draft of the survey. And we succeeded in cutting the survey from 184 questions in its first draft down to 89 questions in its second.

The second draft was sent to the entire task force asking them for recommendations on that draft of the survey, to make any changes, deletions, or additions, and the final draft was developed through a series of communications between Phil Romero, Hattie Skubik, Alain Enthoven, Sara Singer and me.

The final draft was sent to the Beal Research Corporation at the end of last week or Monday I think for pretesting for the length logic and clarity. I'm pleased to say we do have a survey that's 25 minutes in length. And the final survey after it's finished being pretested by field will be sent to all of the task force members so you'll know exactly what it is we're asking consumers of California.

In terms of the content of the survey, I've listed sort of the major sections of the survey to give you some idea if you haven't had a chance to review the latest draft. We're getting information about the individual's health insurance coverage. In fact, we're asking them to read the name of the their health insurance plan exactly as it's written on their health card, health-med card.

Our purpose is not prepare individual health plans, but to be able to classify health plans by brand type so we can compare our experiences across HMOs, PPO, and indemnity plans. We're also getting information on the plan characteristics, information whether or not they have a personal doctor, and their experiences with that doctor, their choice of health plan physicians, specialist care, hospital care, specific problems that they've had with the health insurance in the last 12 months, both type and severity, the grievance process that they've pursued, and the extent to which their problem was resolved, satisfaction with their health insurance or health plan, public opinion on some specific policy options that the task force might be considering, and finally information on the respondent's health status including mental functional and physical health status as well as demographics.

So it's quite a comprehensive survey. My expectation is that we will provide you hopefully with

some excellent data upon which to build for recommendations, and I'm happy to answer questions.

CHAIRMAN ENTHOVEN: Thank you. Questions from task force members?

I'd like to compliment you on your patience and wisdom coming through this very tough process. I mean, I've learned a lot by watching, and it's not easy. I gather by your rattling those questions that you ask people, but it turns out to be a very complex issue.

One of the questions that came up was Harry Christie suggested that we get the names of people who have complained to the DOC and sample them. Which I thought was a pretty neat idea from point of view kind of a high octane way of getting at people who are unhappy about the system.

As far as we've been able to ascertain so far, that the probability is very high approaching certainty that the lawyers think that to use those names and phone those people would violate their confidentiality, and that we won't be able to do it. But what we have tried to do is approximate Harry's suggestion by a procedure in which we identified people who say they are dissatisfied or they've had a problem and also to sample a frequent usage. So thank you very much, Dr. Schauffler.

DR. SCHAUFFLER: Thank you.

CHAIRMAN ENTHOVEN: Now, we will proceed

to the phase of public comment. We have two speaker cards which is merciful, that means we will be able to get to lunch sooner. The first one is Lynnie Morgan.

Let me just ask you, Ms. Morgan, before you comment that at the bottom of your card you say you want to talk about the grievance process and regulated managed care. We will be having some discussion this afternoon about the dispute resolution process. Would you prefer to comment after that or would you prefer to comment now?

MS. MORGAN: That was one of the things I wanted clarification as I stepped up to the microphone. Am I going to be able to have an opportunity to do that and will there actually be task members left by that time? Because I'll do it now.

CHAIRMAN ENTHOVEN: Okay. Let's go ahead. If you're concerned about that, let's just go ahead now, and then on deck if we could have Gerda Miller.

Please proceed.

MS. MORGAN: Thank you. I had a phone call on last Thursday, and the reason I'm telling you this is because I'm going to use my family as an example of what I would like to recommend to the task force.

Last Thursday the culmination of 20 years of my life's work came to an end in that a doctor in Southern California that we had contracted and Kaiser had also contracted through my grievance, the grievance

process, and through a complaint filed with the California Department of Corporations found my daughter's disorder. We've been looking for 20 years for this disorder.

In the last seven years I have spent almost every waking hour pursuing avenues in the state of California to define my daughter's diagnosis so that she could receive proper care from her physicians and from her HMO.

My daughter is missing 3,000 base pairs of mitochondrial DNA out of a possible 16,500 some odd base pairs of DNA. What is wrong with the system where I have to picket and file a complaint with my HMO? I have to go past a mediation thing where I have to pay more money to have an opportunity to do that, have a voice, and then I have to go to the State Department of Corporations to be heard. Then if I don't get the answer I want from the State Department of Corporations, I have to go to an intermediate person. The next person up from that is the governor.

What I would like to have met by the task force is that you reinstate the doctor-patient integrity by stronger regulations from the Department of Corporations. But I'd like you to go past that and consider that in a political climate in a state of California where we have a governor who has already said that he is going to veto bills, and that things won't be enacted until 19, what, '99? My daughter will be dead

by that time, and my son who is 18 now will be married and not knowing whether to have children.

I think that the scientific survey that you're talking about is great, but I would ask that you would consider the accountability factors of this survey, who are we accounting to? Are we accounting to the current government? Are we accounting to residents of California?

And I am impassioned, my friends. I'm 20 years impassioned. I'm sorry that there are no pure consumers on your board. I would have wished that you at least had a percentage of pure consumers.

Thank you for my daughter. Thank you for me and giving me an opportunity to speak to you. But I would just call on you to have the integrity that the state of California residents hope that you do have and vote in favor and instill things that are in the best interest of the consumer slash patient. Thank you very much.

CHAIRMAN ENTHOVEN: Thank you very much. Ms. Gerda Miller from the Gray Panthers.

MS. SEVERONI: May I just say one thing? I just want to thank you. This is the third time, is this correct, this is the third time that you have made the time to speak to us, ma'am?

MS. MORGAN: Are you talking to me?

MS. SEVERONI: Is this the third time?

MS. MORGAN: And I would have been in

L.A., but I couldn't afford it.

MS. SEVERONI: Yes, and I just want to thank you for coming, and I just want to say I could not imagine how frustrating this experience has been for you. I don't think we know as individuals, but we are hearing what you are saying, and I know that I would personally work as hard as I can to see that we can make some progress here. But thank you for coming because I can't imagine even having to, after all that you have been through, actually fight so hard and come before us in this room, so thank you very much, and I think you've been fair.

MS. MORGAN: Thank you.

CHAIRMAN ENTHOVEN: Thank you, Ellen. All right.

MS. MILLER: My name is Gerda Miller, and I addressed you already last time in San Francisco, so I would not like to repeat what I said.

First of all, I want to thank you for standing up to the governor and telling him that he should not use you as a scapegoat, and he should go ahead to pass the legislation that we fought so very hard to get through.

I also want to say I was happy when you addressed, when you came to Oakland, but it was again the agenda, your agenda, is only really decided ten days ahead of time, and until we hear of it, we can never publicize it. And I wish that there would be more

hearings where you can really see ordinary people. I have a list of about 12 people who already have horrible experiences with HMO, but they can never come to talk to you.

My suggestion to you is do you have any written -- any people to write to, can you publicize what you are doing? Because nobody who isn't like I, in an organization and working for health care, anybody of the public doesn't even know what you are doing. And I would suggest that you communicate more with the public so the public can really participate. We don't have many consumers in your group, but we have many consumers who would like to talk to you. Thank you very much.

CHAIRMAN ENTHOVEN: Thank you.

MS. SINGH: In response to the last speaker's comments, we do have copies of the task force meeting schedule on the table there, and it will list the forthcoming meetings. In addition, you are welcome to submit any comments that you have on managed care to the task force by sending them to the task force address. I will leave a small pile of my business cards at the big table as well. As I mentioned earlier, we have a web page now. So we are trying very hard to get our word out to the public. Thank you very much.

MS. MILLER: Thank you.

CHAIRMAN ENTHOVEN: All right. Without objection the meeting is temporarily adjourned. We'll break for approximately one hour for lunch.

(Recess taken.)

CHAIRMAN ENTHOVEN: Will the task force please come to order. I want to thank the Scottish Rite for this rat-free environment.

Okay. We are ready to proceed discussing the work of task force members which I think is pretty important. And we're very grateful to you for your willingness to engage on these issues. We have four that we want to discuss today. The first one is expanding consumer choice, John Ramey and Allen Zaremberg.

Let me just say by way of introduction, that from early days in the HMO movement back in the days when we thought of it as a movement and not as a business, one of the cardinal principles was individual choice. And that was in part because Kaiser Permanente, which was the pioneer, the Permanente doctors did not want to be required to take care of patients who really didn't want to be there because they felt that was not a good basis for a doctor-patient relationship, and what they wanted were volunteers.

So they pioneered the idea of at least dual choice. I mean it was usually Kaiser versus Blue Cross or Kaiser versus medical service. That was kind of the whole way things got going. And not until very long ago that was generally the idea, for example, the federal government in 1973 the HMO Act trying to open up the market to HMOs has passed the prevision HMO Act that

every employer is subject to the National Fair Labor and Standards Act is essentially 25 or more employees would be required to be offered as a choice -- if they offered health insurance, then they would have to offer one group practice and one individual practice HMO if such HMOs existed in their area and wanted to serve -- offer to be served their patients.

And that performed an important role in kind of opening up the market to competition and extending the notion of competing health plans. What's happened in more recent years is we've gotten a lot of single plan replacement, and so many people who previously were at the fee-for-service suddenly found themselves in an HMO without a choice.

And I think that there are a lot of important things about choice including if you get in the habit of your health plan, and you have a choice you always go by how you can get even, which is the next annual enrollment I'll switch to plan B. And that would be one of the number of safety dollars. Also if the health plan knows you have a choice, they are more likely to be motivated to be responsive to your needs.

So I think the work of John Ramey and Allan Zaremberg is very important. It's tough because the state is highly constrained by E.R.I.S.A. which prevents the state from regulating employee members. I really appreciate the work you all are doing, so I'll turn the floor over to you.

MR. ZAREMBERG: Thank you, Alain.

Let me say that this is clearly a work in progress. We're a long way from reaching any concrete recommendations. Choices I think probably made more difficult in health care than anything else because as we discussed previously at a meeting, the economics are different because one individual or entity pays and another consumes, and that makes a choice unique to health care and how you go about it.

Most -- well, not most, but a large percentage of Californians do not have a choice of more than one plan. And many Californians are obviously in that particular situation may not be able to know who all the available physicians are.

I think I'll cut to the chase, basically, John and I do agree on one thing, I think, and it's a question of how you get there. Well, a solution how you encourage choice. And encouraging choice would mean that more people would be in purchasing pools, and that in those purchasing pools, and there's a couple different types of those which I'll get into in a minute. But that each purchasing pool has a superdirectory of physicians, and I think the HIPC has moved towards that, and one of the other options for purchasing pools which is more of a marketing type of situation. Warden Brown is also doing that, and they do that because they believe that people will want to use their purchasing cooperative because they have a choice

of positions.

So briefly let me go through them, and basically we believe that whether you're a small, medium or large size of employer, you should be able to offer your employees a menu of health plans. PERS obviously has the most and is probably the most well-known purchasing pool. I don't believe that we have to -- I'm not sure. I don't believe they have a superdirectory of physicians, but as the HIPC does, and the theory is that you as the consumer, even though you may not be purchasing it, you can look at the directory of physicians and decide which physician you want for your primary care physician, if that's the way you wanted to choose. You can either choose it that way or you can choose it by means of the health plan based on information that you have. And either cross reference the physicians to a particular health plan or take the health plan and look back to the physician. And we believe that is the best way to encourage choice in choice of plans and in choice of primary care physicians.

I can also, at least from my perspective, and I don't know how John feels about this, but the employer -- whatever employer wants to offer in terms of an employee benefit, it could very well be a hundred percent of a plan which would be an HMO plan, and then if you wanted to have outside access to physicians outside the network, then the question is, "Does each

individual consumer want to pay that additional choice -- exercise that choice and pay that additional premium?"

There's -- that creates -- that brings into play some of the economics, traditional economics of elasticity for the consumer that they do make some choices based on their own economics as to what type of plan they want.

I think the difficulty that we get into in why we are a work in progress even though we do have this recommendation is how do we get there? What is the best way to encourage this? It was this legislation that was authored and signed into law last year SB 1559 by Steve Peace, and the governor signed that sets up a process through the Department of Insurance to license and encourage more purchasing pools.

To my knowledge, at least the staff indicates to me, that nobody has applied to create their own purchasing pool. There are market arrangements such as Warden Brown and that have clearly begun as a way to market this. We heard from Bob Crichlow also who has established purchasing pool for eight agents in the Bay Area.

The legislation of 1559 puts a restriction on who can direct the purchasing pool and precludes agents and brokers from doing this, and I think John from his experience at the HIPC agrees with this. But it is clearly an issue that I think we need

to pursue a little further. And the reason being is because we see where there are purchasing pools that have been developed whether they be Warden Brown or Mr. Crichlow's, the agents and the brokers who make a great deal of influence in the small- and medium-sized markets are the controlling factors. And I think we need to recognize that and see if there's a way to ensure the integrity of a purchasing pool, and at the same time bring their incentives, which are business incentives, into the development of more purchasing pools.

We see when we look at the data that employees in large plans have choice for large companies, government employees through PERS have choice, but even in the small sector market where we have created the HIPC, which is now turned out to be the private ties, we see a slow growth, and once again I think some of that -- and it provides choice, I mean it's the things we want a superdirectory. They provide choice plans, and it's a question of how much do the agents and brokers influence the process by encouraging employers to make those decisions?

I talked about elasticity a few moments ago in terms of the consumers, but it's clearly the elasticity in the employer market. And they are very price sensitive, and for when you get into the issue of choice, employers to a great extent are concerned certainly in a small employer market and in the medium

sized market about the increase in their health care costs as the ability to stay in business. So more often than not, they will make decisions based on their ability to continue to afford health care, and that's why purchasing pool we think allows them to do that and at the same time allows them to provide choice.

One final thing, we do have some recommendation that we're going to put in writing for you that have come from the people that operate Warden Brown that make that process much more streamline. Since it's a marking arrangement, each employer's employee has the ability to choose from a menu, but at the same time they have to contract with each individual plan, and each individual employee rather than to do it as a purchasing pool would do, like the HIPC, in a more broad based process. And that's one of the things they suggested we needed a little work in it. And that may encourage more, I think, more of these marketing arrangements to allow employers and our employees to have a menu.

What I think where we need to work and where we need to help, we'll probably be sending out some recommendations that are some ideas and asking for some input back that is asking, "How do we encourage the creation of more purchasing pools?" And what is the way to do it? And part of it is I think there would certainly be -- our employers are not demanding it right now, and I think otherwise they probably would see more

of them. And so -- that's -- we need your help, but that is I think our goal is to provide choice to the employee both in terms of plan and provides choice to the employee in terms of their physicians because if you can set up a superdirectory, they can make decisions based on that.

MR. RAMEY: I believe Allan has pretty much covered our discussions. He and I have been having this discussion for over ten years now. Our roles have changed, but the discussion's pretty much the same. I think that it's characteristic of deliberations over health care policy that we all, I think, would pretty much agree on the broad policy goal more choice in the marketplace. And then struggle mildly to figure out a way to accomplish that choice upon which we would all as readily agree.

I am struck by the fact that I believe that we are having a luxury of these discussions based upon the previous ability that we've seen in California essentially since 19 -- at least 1993. The competitive manage care market system that has produced that premium stability can be undone. And we're going to need to be very careful that we don't do things that would again cause a focus to be almost completely on price and at the expense of discussion of quality.

One of the things that is a primary factor in thinking about creating more choice in the marketplace is risk selection. Because as you create

more choice, you also create the danger of a more severe risk selection. If we had, for instance, a thousand or 2,000 purchasing alliances in the marketplace, how might they distinguish themselves from each other? My primary fear is that the primary distinguishment would be over which alliance could attract the best risk, not over which could produce the best product for the consumer. And that kind of risk selection in the marketplace is an ever-present danger because we have all seen the impact of that in the marketplace and to our California's credit it has done -- taken some bold steps to try to eliminate this selection in the marketplace as much as possible given all the different views about it.

We developed a fairly long list of possible options that we might have to encourage choice. And we tried to array them from the least intrusive to the most intrusive to the present system. The options that Allan has described are the ones that we can agree on are the ones that are the least intrusive.

You can go to the other end of the spectrum and say that what we could have total choice of providers in the state by having a complete system in which we demanded any willing provider for all health plans. In my opinion, that would destroy the competitive market that has produced the premium stability that allows us the luxury to focus upon other values in the equation.

So I -- my intention here is to give you

a little bit of a sense of the complexity of this discussion. Once you get past the idea of, yeah, we all want more choice, then the "how do you get there" is a pretty rocky road to travel.

MR. ZAREMBERG: Let me say one final thing, Alain, and based on one of the things we considered, we will include I think when this gets done in writing. I don't necessarily know whether I agree with it, but I think we need to put it out there, and that was, "What type of role does government have?" And one of the suggestions was, "Should we provide subsidies for the creation of purchasing pools? Should we provide subsidies for employers who use that?"

I think we need to look at that in a broader context, and this is sort of a request to the staff, for all 16 ERGs that you have where there is a situation for a request for subsidies or things like that, whether it be tax or otherwise, basically what you're saying, this is where taxpayers' dollars are going to go. And does it belong in this situation?

Well, if we decided there ought to be taxpayers' dollars collectively used in some way in health care, and, you know, is this the best place to put it? Another way may be in self-insured. In the self-insured who can readily buy insurance if you're healthy, but if you're unhealthy somebody has to subsidize it.

So all I'm asking, that's a consideration

we've looked at, but it's a consideration I think a lot of people will look at for their various topics if they're going to look at them. And I think when we're done with all the groups and put them together, we say we have five different people who are encouraging tax subsidies. If it's appropriate, say if government's going to spend money in health care, where is it best spent? And not looking at them on an individual basis, but looking at them all collectively.

CHAIRMAN ENTHOVEN: Thank you.

DR. ROMERO: Thank you, Mr. Chairman.

I want to come back to this with where the ends meet and the whole issue of mechanisms. And as John Ramey alluded, and both of you did, there's a spectrum of possibilities from very voluntary to very intrusive. You've mentioned one or two points on that spectrum. I don't want to pin you to a specific suggestion because for one thing I think you had at least two, at least, but I wondered if each of you could answer a question. Where is the boundary of your personal comfort zone? What's up near the edge of, you know, of starting to get there?

MR. RAMEY: Where my comfort zone completely ends is where we begin to contribute costs to the system above that what we have now. Because I am ever mindful of the fact that we have several million people in this state that, working people, that cannot afford this product. Where on the cost of doing

something very significant, in terms of their children, but that doesn't mean anything from my 23-year-old married daughter who is not working in a high paying job and having a hell of a time paying for her health insurance, and I think that that is something that we just cannot lose track of. And so when it begins to add additional costs to the system, I think it's a luxury that we shouldn't be considering when we got several million people in that state that we still need to deliver this product to.

CHAIRMAN ENTHOVEN: Well, John, there's a certain contradiction that you're saying; that is, I think it's competition among managed care plans that got us to cost reduction. So we're talking about more competition, I think that leads to cost.

MR. RAMEY: Yes, it is competition among health plans, but it's also been competition amongst providers, physicians that has produced those savings because let's face it, in a system like Allan described in which you have a provider -- a reverse provider directory, most people's number one way working that is they know the physician that they want, so they say you know, "I want Dr. John," and then they look and say, "Now where can I buy Dr. John for the least premium dollar?"

That's health care in my opinion, and now working for a CMA subsidiary -- I'm probably way out on a limb here. So, yeah, it's competition most health

plans, but when you get down to the choice factor, you don't mess with that. The health plans are not going to by themselves just miraculously produce the premium stability.

CHAIRMAN ENTHOVEN: Okay. Members?

MR. ZATKIN: Alain?

CHAIRMAN ENTHOVEN: Yes?

MR. ZATKIN: Two questions. One, John, you ran the HIPC for some time. Can you tell us what you think the barriers or disincentives were to selecting them, and, two, did you look at the question of expanding the eligible group size?

MR. RAMEY: When we -- when Mr. Mid, and I was with Mr. Mid at the time that we started the HIPC. One of the things that we had in mind at the time, and price was a lot more of a consideration in the market than it is today I believe. One of the things that we were attempting to do is to select cost centers in the system and try to reduce price in those cost centers. And so we adopted a lot more stringent system in connection with agents and brokers that was generally prevalent in the marketplace. And a lot of our advisers and friends in the market told us that that was an obvious mistake that we were making.

I think that that has played a limited role in the -- well, the modest amount of enrollees in the HIPC. But I also think that folks who think about the modest amount of enrollees in the HIPC don't really

understand how difficult it is to introduce what is essentially a new product in the system that is completely voluntary and competing with all other products and with literally no marketing funds.

If you think about it in that regard, the growth and the HIPC has been absolutely quite phenomenal. And so it takes an appreciation of how difficult it is to introduce a new market or new product in the California market, which is very mature managed care market, and get people to switch from wherever they are to that product takes a tremendous amount of effort, and all of the things that are competing health plans do is essentially geared towards that. And they have much better resources than the HIPC has ever had for that.

That's one. So the second thing in terms of group size is, yes, there has been consideration for the HIPC to serve groups larger than 50 or for it to serve individuals. But as a completely voluntary product, the HIPC, any purchasing alliance absolutely cannot go where the market does not go. And if there's no underwriting reforms, guaranteed issue, rate bans, et cetera, in those markets, it's very, very difficult for the -- for a purchasing alliance to operate in those environments without engaging in the medical underwriting practices that are hard to bring off in a purchasing alliance where there's individual selection because composite rating, you know, when we can get into the details of composite rating, it's very difficult

because of the employee selection, et cetera, et cetera.

So what the bottom rule is purchasing alliances are not going to thrive in places in the market where they're at a disadvantage in terms of risk selection.

MR. ZAREMBERG: Finally, it's a complex question because as John said if you expand the market say to a hundred, he believes, I mean in his experience he just said you need to put the marketing reforms and guaranteed issuance in there. And the question is does company capitate on the PPO market first or the HMO market. And are employers left with fewer choices than what they want to purchase, and is that good?

I'm not sure if you achieved anything. You may make things more difficult because if you have to get a guaranteed issuance in order to expand the HIPC and make it something that you can market or something the market's out there, maybe you have destroyed an option for certain employers in buying a tailor-made PPO policy, and in that 50 to the 100 category, and is that good? And that's true the trade-off that you have. I'm not sure -- I don't know whether -- I don't have a conclusion on that whether it's good, but I'm not sure to eliminate that choice.

CHAIRMAN ENTHOVEN: John?

MR. RAMEY: I would -- just one more thing, and I know this isn't really on our topic area, but I think the more choice you have in the marketplace

the more it begs it is if we really want the kind of choice that we're talking about in the market, then I think risk adjustment in terms of quality is a necessity. It's always been part of the competitive marketplace configuration when you got, you know, when you have all the pieces of the model in place, and in my opinion, it's the number one thing that we could do to enhance quality in the marketplace because providers who excel in high cost procedures wouldn't be put at competitive disadvantage if there is risk investment.

CHAIRMAN ENTHOVEN: Right. I do hope the task force will be willing to recommend that we move forward on this adjustment.

MR. LEE: Recognizing there's overlap between a lot of the ERGs, I just wanted to note is what we want is choice, but we also really want informed choice, and this is where a lot of overlap becomes another group just because they have a lot of options, what they're choosing between isn't very helpful, and it's not just what they're choosing between, but what they're getting. One of the examples that you noticed in the yellow flag about, is the superdirectory is great. The people need to understand that if they're picking a doctor, what goes about that doctor may be what they get the medical group next they know nothing about, and that may limit 18 options down the road. And so the issue of choice I'm just encouraging to consider both the financial issues and purchasing issues, but

also to inform them.

MR. ZAREMBERG: That's true, and I think it's important to know that when you have a superdirectory and a number of plans, you can make your choice either based on your physician or on your plan, so the whole idea is to give people the option.

You know, one of the -- as we talked in answer to Steve's question, there's always a consequence to everything you do, and sometimes it's not always what you want. The more choice you have, and you'll see this in PERS every time they have their open enrollment, the more money that you have spent on marketing to individuals, and that's money -- we hear complaints all the time against managed care or against health insurance industry in general for spending too much money on administrative and not enough on treatment and quality. And what you do when you got a choice for individuals is you require, as Peter said, information to individuals, much more information and marketing and advertising that is money that is taken away from treatment. There's no two ways to get around it.

CHAIRMAN ENTHOVEN: Well, PERS total administrative overhead costs including the costs of writing and printing and distributing the report cards and other explanatory materials and running the whole thing and everything else comes to three-tenths of one percent of premium.

MR. RAMEY: But that doesn't include the

cost of plans trying to convince individual PERS members to sign up. Differentially, it costs a lot more than it does going to talk to Tom Elkins.

MR. ZAREMBERG: I encourage you to spend a little time in Sacramento during open enrollment and you'll see all the money that's directed towards getting people to join one plan or another. And that is money and I said if you do the same thing throughout the entire state for every individual that there will be a great deal of marketing.

CHAIRMAN ENTHOVEN: Would you favor significant need and compulsory a sign people need plans?

MR. ZAREMBERG: Alain, I'm not saying that's bad. I'm saying that that is a consequence. That is --

CHAIRMAN ENTHOVEN: That sounds very capitalistic to me. Clark?

MR. KERR: Sometimes there is a difference between information and advertising is the comment.

Secondly is back when I was with Bank of America, for a while we did advertise. That was not something that we fanned away from, so I don't think this is a disparage on your side.

MR. ZAREMBERG: It's not an argument, Clark, it's a fact. It's just a reality.

MR. KERR: But people, and I'm not sure

it's different than what's being done right now.

CHAIRMAN ENTHOVEN: People got all the information from PERS. I mean they can disregard all the literature and other information.

MR. ZAREMBERG: Clark made a good point there's a difference between information and advertising. And the reason people do advertising is because that's how many people make their decisions on advertising.

MS. SEVERONI: The one thing that we did was Medi-Cal beneficiaries 300,000, we said no advertising by the plans. There was none. All the information came through Cal Optimum about the other plans. It was just one of those ways of saying that we really didn't want to see those dollars spent that way.

CHAIRMAN ENTHOVEN: I think the federal employees have something. I did live inside the Belt Way in the east, and I don't know, it may have changed now, but I think they had something about that. Ron?

MR. WILLIAMS: Thank you. John, just a couple questions, and then I'll preface them for you --

CHAIRMAN ENTHOVEN: Closer to the mic.

MR. WILLIAMS: Our view is that I mentioned we're not in the HIPC, we are a supporter of the process. We think it represents a good competitive option for many employers. As an organization of our size we feel whatever it comes to offer in time of choice, and we do offer choice at the individual level

for a member of an HMO or PPO.

And one of the questions that I'm curious about is I've noticed recently that one of the limitations that seems to be running up against is often in the individual choice of PPO plans, and I know you spent sometime there and been on the other side of the fence, and choice is such an important part I believe of what our firm offers, and I believe what ultimately all plans have to offer, I'm curious about your comments about the challenges the HIPC face in offering kind of member level choice for the HMO plan and the PPO plan which we think is very important.

MR. RAMEY: No doubt about it the fee-for-service of plans, PPO type constructed at least, have not thrived in purchasing environment, and that's true in PERS too. And I think that that goes back to a basic economic fact that capitation is a very powerful economic incentive in the system, and that fee-for-service has a very hard time competing on an economic basis, and in addition to that it is also a risk selection problem, and the -- you have to give MRMIB a lot of credit for stepping into the risk adjustment quagmire and trying to address this issue as best they could get 25 health plans to agree to it. That's like herding cats, but the risk selection mechanism that everyone can agree to is not very finite in that it -- well, requires a hospitalization, and we all know there's a lot of expense for some diagnoses

that don't involve hospitalization.

So your observation is quite correct that purchasing alliances have not -- that fee-for-service plans have not been able to thrive there. And it's for both risk -- both issues for the same benefit level and price and for, secondarily, and probably even more importantly risk selection.

MR. WILLIAMS: I guess what that leads me to is something that needs to be sensitive to endorsing that as a model -- you were saying that the limitation of the technology today suggests that you can have any plan that you want as long as it's an HMO as opposed to more real choice where at a member level the individual can pick PPO or an HMO depending upon their own preference.

MR. ZAREMBERG: You know, I know Richard Spohn is here. Do you know if Warden Brown has PPOs in their market or they're just market agent level HMOs? Just HMO Richard?

MR. SPOHN: There's one company offering four PPOs.

CHAIRMAN ENTHOVEN: Donna?

DR. CONOM: I'd like to go back to the point about advertising disclosure not being the same thing at all. Maxine has very specific disclosure laws. One of them was handed out with the Thompson Bill in our packets today, and those essentially aren't being enforced. If they were enforced, then perhaps there's

something this task force could do in terms of encouraging the enforcement of those disclosure laws so people could make more informed choices.

CHAIRMAN ENTHOVEN: All right. Okay. Michael and then Keith.

MR. SHAPIRO: I have a question. Chairman Enthoven mentioned the risk, and I'm wondering if you can briefly elaborate on strengths, you know, E.R.I.S.A. and recommend where -- how individuals are required for dealing directly with employers, and in your conversation you mentioned at least one state that may be pushing the envelope. Is there information that we can get from the state?

CHAIRMAN ENTHOVEN: Well, we're still learning, just to elaborate, as I'm sure you all have now mastered the fine points of E.R.I.S.A. after mastering the Knox-Keene Act; that is, the Employee Retirement Income Security Act and lawyers, accountants relieve act of 1973. But the federal government preempted the regulation of employee benefits which means that states may not mandate benefit choices on employers. And that would include preventing the state of California from passings a law such as the Federal HMO Act saying to employers if you offer health insurance, then you must offer choices.

So we have been looking around for other examples of anyone who has successfully penetrated that and won, you know, gotten around it, and one that we

found was in the state of Maryland where the state passed a law saying if you are offering a closed-end HMO as the only choice to an employment group, then you must include in that employment service feature, and I mentioned that to Sara Singer who called the people in Maryland Sara -- was it you Sara?

UNIDENTIFIED SPEAKER: Amy called.

CHAIRMAN ENTHOVEN: So Amy you talked to the people in Maryland? What did you find out? This is Amy Jungman MBA from Stanford who is working with the choice group.

MS. JUNGMAN: Just that they actually -- that they couldn't get around E.R.I.S.A. That was the intent of the law, but in the end all they were able to do was make sure that the POS was offered to the employer, but if the employer declined, then it didn't have to be offered to the employees.

CHAIRMAN ENTHOVEN: Thank you. That is -- when you think about it is pretty much of a head-on --

MR. SHAPIRO: Was that litigated? When you say it was resolved, was there a lawsuit the state lost? Did the State not seek to acquire the choice -- I'm trying to understand how that result came about. Was there litigation anywhere?

MS. JUNGMAN: No, there wasn't litigation. They just couldn't pass the law to actually mandate the employer.

MR. SHAPIRO: Thank you.

CHAIRMAN ENTHOVEN: So we'll keep looking.

DR. ROMERO: Quick additional comment on E.R.I.S.A. I mean my bottom line on this is that at present bar and creativity even on the part of California state law makers or federal law makers, I'll come back to that in a second, just as John Ramey said the HIPC can only go where the market goes, that E.R.I.S.A. imposes a constraint on the degree to which we can impose mandates on the marketplace and the employer may choose to put a high shelter around E.R.I.S.A. That's a gross simplification.

The President's task force to some degree to this task force which began meeting in approximately March is having a meeting in early September I believe, and this is going to be one of their topics in Chicago. And we will have a task force representative there as much as anything else to try to get a report on this exact subject. So we hope to have something thoughtful in exactly a month, but we're still on it.

CHAIRMAN ENTHOVEN: Okay. Michael Karpf?

DR. KARPF: In listening to the discussion of choice and informed choice and marketing reminds me of evenings and afternoons I'd spend with neighbors coming over to my house needing an expert on health care choices, trying to explain insurance policies. There were university employees, and they

would have 15 choices, but none of the choices were quite the same, and they were a tradeoff because the issue of making informed choice starts leading to the issue of standardized packages or standardized coverage programs.

CHAIRMAN ENTHOVEN: Yes, in fact the University of California did adopt standardization of the coverage contract, and that turned out to be dynamite in terms of creating price-elastic demand. That is when people understood where there was PacifiCare or Health Net or Maxi-care or Medicare that the contract was the same, then they were much more willing to switch plans and shop for price, and that helped explain why the first year they did that.

Here in California they experienced like a nine-and-a-half reduction in their rated average premium, so that worked.

Yes, Rebecca?

MS. BOWNE: I would be extremely hesitant to have the commission advocate more consumer choice solely through more purchasing pools. And I'm even more nervous about it now that I have heard you speak glowingly of having only one plan design.

For some persons the same plan design is not necessarily good consumer choice, nor is it necessarily affordable for different, not only employers, individuals, different types of groups, so I would hope that in our advocating for consumer choice

even though it may be confusing as to what plans, difference plans offer in their tradeoffs, drugs or mental health or laboratories. And the ultimate is that everything is covered for everyone at a very inexpensive price, but I don't think that's reality. And I would be very cautious in that I know that when we advocate alliances and purchasing pools in order to have some comparison among plans, you need to, you know, to know what are the pools of gains, so to speak, for each plan in order to compare them.

But I would say that we are already getting a very homogenized commodity of HMO choices, and if we truly want to advocate market and free enterprise, we need to structure the rules of the game so that there is some room left for indemnity plans for those persons who care to choose and want to pay for them. And if you put the kind of structure in it that I'm hearing you advocate, I'm concerned that we'll lose that choice entirely.

MR. ZAREMBERG: Can I respond to that, Alain? I think Rebecca makes a good point, and I think the same thing took place in 1991 and 1992, when the legislature was discussing the creation of the HIPC, and I think it's proven to be true. You know, there was a tradeoff there, and I think some people would say the benefits outweigh the consequences, but there will be homogenized plan and I think that's one of the factors we have to consider is how do you encourage these things

and still give the opportunity for a tailor-made plan that meets the needs of a particular employer and can be in some cases, I think Rebecca said, who's willing to pay more, but in some cases it cannot necessarily be any more money.

Can it be a distribution of a type of health care to meet their needs, and I agree with you, and I'm glad you made that point, so when we put our final product together we don't want to discourage choice of people who want to go out and purchase, whether it be on their own or through their employer, a PPO type policy.

CHAIRMAN ENTHOVEN: Michael?

DR. KARPF: My question, Rebecca, I didn't mean one type of plan. I mean a basic type of plan so there would be an opportunity to buy upgrade if you would like. We are very out caring in this country, but I think one of the problems we get into is when people don't quite understand what they want, and think they bought more than they bought. They at least understand where they start, what is covered, then they decide down the road to upgrade. So you know we with health care plans everyone tends to buy mid-size car, but wants a Porsche, but that may not be necessarily work either.

MR. RAMEY: I just have to say that I think it's impossible to do the kinds of things that Peter's talking about in terms of well-informed

consumers and at the same time not have any standard upon which they make the selection.

I got to tell you if we were all actuaries here, and we were talking about five different pharmacy benefits, there wouldn't be two of us that would agree about the value of that pharmacy benefit let alone try to get the consumer to be able to understand what the difference in those values are. You got to start from some standard that's common if you really think you're going to effectively educate consumers.

CHAIRMAN ENTHOVEN: Keith?

MR. BISHOP: The point was made earlier in the Knocks King Act imposes disclosure requirements, and they also have marketing requirements. I believe that was a very important point. I do want to set the record straight on the point about lack of enforcement. The fact is that those laws are being enforced.

In December of last year, I fined one plan a hundred thousand dollars and made them retract the ad and reprint a corrective ad in the Wall Street Journal. They had to delay the information to the program they were advertising for some months as a result of that. Then in January I fined -- it began in process of fining more than 80 plans close to a million dollars for failing to making proper disclosures.

And I guess I would say to everybody here if you have evidence that there are violations to the advertising provisions in Knox-Keene Act bring them to

the Department of Corporations. We're interested in enforcing that law, and we'll look at whatever elements you have. But I think there is a pretty strong record of enforcement of those marketing revisions today.

CHAIRMAN ENTHOVEN: Okay. I think -- thank you. I think we should move on to your next one. That was very good discussion, and thank you Allan very much and all the rest that participated as well.

The next one we get is the complex important issue of Provider Incentive with Donna Conom and Steve Zatkin. Recall that in Knox-Keene there is a provision that if I can summarize a complicated thing briefly, that health plans may not pay doctors or others specific amounts related to the denial withholding of care for a specific individuals. On the other hand, broad-based incentives that were applied to groups of patients and groups of providers are permitted. But this opens up the whole question of fee-for-service, salary, capitation, and the question for the task force is whether we think that the existing legislation is satisfactory or appropriate or whether we want to recommend in some way or other going beyond that.

Donna or Steve?

DR. CONOM: I'm going to start.

CHAIRMAN ENTHOVEN: You're going to start. Okay.

DR. CONOM: And if you have an outline from me labeled "Incentives Expert Resource Group."

Does everybody have that?

I'm going to go through this real fast in terms of background. First, I should declare my conflicts of interest which probably we don't do enough of in this task force. I'm a physician. I'm a specialist. I'm in private practice, and I have contracts with a lot of different kinds of groups. Most of my work is fee-for-service, sometimes modified withholding. I'm discussing a large capitated contract with a group that has 150,000 lives right now, and I work with both fee-for-service and capitated pediatricians, some of whom share risk pools.

I'd like to, before I make an excuse, this presentation is a month before it was supposed to be due, so it's also a work in progress like everybody else's. And I would like to acknowledge the help of Sara Singer, Ruth Givens from CMA in San Francisco, and Judith Regal with CMA in Sacramento who provided me with piles of material to read.

In general, there's been a pendulum-type swing for fee-for-service indemnity insurance decapitation via managed care. The pendulum needs to swing back somewhere in between since both extremes have drawbacks. Physicians do understand why we have managed care. I always mention this in my managed care presentations.

I'd like to direct your attention to the cartoon on the fifth page of the handout, one of my

favorite cartoons, and just to show you that I do understand why we have managed care.

Managed care is now done in HMOs which are mostly capitated in the staff model, and a lot of this information by the way that I'm going to summarize quickly is from the Steve Latham article that you got in your packet on the green paper. It's done in HMOs in staff models, group models, with shared overhead, IPA models and network models. Or it's done in PPOs mostly discounted fee-for-service with gatekeepers, second opinions, case review or utilization, education for providers, preventive care protocols, financial incentives to decrease utilization such as co-payments and deductibles.

Basic physician payment then is by first of all fee-for-service. And keep in mind these are physician definitions a lot of them, and fee-for-service means to us more work, more pay for more work, the highest volume workers get the highest pay, and doctors with low volume, we usually feel, with low volume practices are the ones who are likely to over treat.

Fee-for-service can be modified by practice management protocols, discounted contract networks, discount in return for volume, incentive payment modifiers, withholds, bonuses.

The second basic physician payment method is salary. As employees are independent contractors with a preset guaranteed income. These are -- the

salary can be modified with bonuses which may be calculated by complex formulas including hours of work, encounters, patient satisfaction, malpractice suit statistics, mortality and morbidity, et cetera.

The third basic payment mechanism is capitation which is a fixed payment per patient per month usually paid to either an individual directly from the HMO or from a group for professional services only or in a method called subcapitation which includes professional services, plus it may include referrals, tests, hospital costs, and pharmacy costs. Or capitation can be paid to groups, either large or small, who then pay individuals by either fee-for-service or capitation, so this becomes very confusing and very mixed.

If groups -- if capitation is paid through groups who then pay by either capitation or fee-for-service, that's a three-tiered system. And these are modified by bonuses, withholds, risk pool sharing, especially hospital risk pool sharing and modifiers of cap rates include patient risk factors especially for chronic illness which was mentioned before and will be again I'm sure, stop-loss insurance or bonuses or other incentives, and one I forgot to mention is carve outs of various diseases.

Physician complaints when you hear about capitation are as follows: That it creates financial conflict of interest "my patients versus my kids;" sick

patients may get inadequate care; and encourages "cherry picking;" discourages becoming very good at taking care of chronic and severe diseases; encourages rationing by inconvenience when rates are low; decreases time spent per patient when rates are low; reduces choice and ability to change doctors; risk has to be taken for factors outside of the doctor's control; it may create both windfalls and financial disasters; it may cause patient distrust; it increases liability; and it decreases continuity due to frequent panel changes, and it's hard to refer patients with problems to capped primaries.

An example in my own practice, and I am a neonatologist, so I create for babies that have a lot of problems, and I have trouble finding pediatricians who want to take on those babies with complex problems because of the low cap rate.

Incentives can be compared in intensity. If incentives are too intense they result in inferior care even if one assumes that physicians desire to give good care, however, physicians are only human.

Incentive intensity decreases as the number of decisions, patients, or doctors increase or if less than 40 percent of the individual's practice is involved or if calculated over a longer period of time.

Incentive intensity increases as the frequency of calculations decreases over shorter periods of time, as numbers of patients or doctors decrease and

as numbers of dollars decrease. For example, a hundred dollars incentive for discharging a maternity patient early is too intense because it only involves one encounter. It's now illegal by AB 2649.

Incentives spread over large groups are less intense than small groups. Large groups also have the advantage of cooperation and peer pressure.

Physicians are having more ethical problems with capitation, earning more by doing less, than with fee-for-service, earning more by doing more, because they feel that doing less is more likely to conflict with the patient's best interest. Physicians feel a moral obligation to give good care, intense incentives are more likely to cause a conflict of interest. Physicians also have incentives other than financial which drive them to give good care and work hard regardless of how they are paid. Decisions physicians must make on a daily basis to do the right thing for any particular patient are not particularly easy even without financial incentive factors.

Most physicians feel that managed care can be put to work and needs modification, and I listed there some of the things that CMA has been working on. I'm not going to read them, but there are things that have been mentioned here already such as risk-adjusted capitation, et cetera.

The ideal patient-physician relationship includes choice, competence, communication, compassion,

continuity, no conflict of interest, and confidentiality.

A successful incentive strategy is perceived as fair by individual physicians, is easy to understand, has a quick impact within a few months, has a positive compensation structure using carrots, not stick.

I've listed there a statement from the AMA "Principles of Managed Care:" "Physicians must disclose any financial inducements or contractual agreements that may tend to limit the diagnostic or therapeutic alternatives that are offered to patients, or that may tend to restrict referral or treatment options. Physicians may satisfy the disclosure obligations by assuring that the managed care plan makes adequate disclosure to patients enrolled in the plan."

Steve and I have had some discussion, and I'll turn this over to him to discuss the options and the things we can so far agree on.

MR. ZATKIN: Thank you, Donna.

We did send out to the task force a questionnaire in which we asked about your opinion regarding some options. We received some responses, not all. I would urge those of you who have not responded, to do so, and we'll probably query you again later on in the process after we've had this and other discussions.

The issue that's before is whether there are incentive arrangements which would be to provide

less than appropriate levels of care and what we should do about them if they exist. As Donna indicated from her presentation, this is a very complex subject. We did eight hours on the titled compensation approaches. The basic approaches to compensation which include fee-for-service, salary, financial incentives which can apply to either of those cases, capitation at the larger level, capitation to individual physicians or small groups where there is risk for referral, and then capitation to physicians for primary care services only and capitation for specialty services only.

In addition, the second page notes how risk sharing incentive arrangements may be structured, and these would be on top of the basic arrangements, and they may vary according to whether a physician receives a share of surplus is at risk for deficits, a combination of those, and whether the physician is measured according to individual factors, those involving the physician's own practice for aggregate factors. And when we look at the question of intensity as a way for marketing points, we need to keep these differences in mind.

And then the third page of this handout notes some of the other factors that come into play in determining the nature and intensity of the compensation and incentive arrangements.

The complexity of this issue is I think illustrated by the conclusion of the organization called

the Advisory Board. The Advisory Board consults on physician compensation and other managed care arrangements, and they have calculated it using just the basic approaches to physician compensation. There are more than 431,000 combinations.

I'd like to talk a little bit about how physician incentives are currently addressed in law, both federal and state. At the federal level if a health plan participates in Medicare or Medicaid on a prepaid basis, it is subject to a set of rules. And the first rule is a prohibition against an incentive arrangement that is inducement to limit or arrangements in services to an individual enrollee.

Donna noted that in what is a modest prohibition. There aren't very many circumstances under which that does or has ever occurred. In addition, if a plan has a what's called a physician incentive arrangement, it places a physician at substantial financial risk, then the plan must meet certain requirements.

Now, substantial financial risk occurs when the physician is at risk for the cost of referral services in an amount that exceeds 25 percent potential payment. If that is the case, then two things must occur. The plan must provide stock laws protection, and that will vary according to panel size, and in addition there must be a survey of members for satisfaction. So that's the federal rule applies to plans that are

involved in a prepaid basis of Medicare and Medicaid. And I would indicate that most of the health plans at least the California Association of Health Plans are in one or the other of those programs on that basis which doesn't mean that the rule applies in all cases because it only applies with respect to providing -- involved in those programs Medicare and Medicaid, although it would be difficult I think for plans that use different approaches.

Now, at the state level the Department of Corporations requires medical decisions to be free of administrative and financial involvement. And DOC does review applications as they come in with respect to their physician incentive arrangements; although, I'm told that that is not an ongoing review. It's an additional review, AB 2649, which was enacted last year, and a state statute which does two things.

First it prohibits specific payment for the purpose of reducing the limitation with respect to enrollees or group of enrolllees with specific limitations. I said slightly broader than the federal prohibition, but not much. It also requires health plans to disclose in their disclosure form, and in their evidence of coverage, the basic method of reimbursement that is used and whether or not financial incentives are used. It doesn't require disclosure of the nature of financial incentives issued as being addressed in legislation by Senator Rosenthal which has not yet

passed.

MR. SHAPIRO: I'm not sure what we have is -- I think that issue is before the legislature. I believe it's --

MR. ZATKIN: I'm sorry, if I identified it incorrectly. Now, the question what should be done assuming that there are incentive arrangements that are a problem. Are there those which are so adverse that they should be prohibited by law in addition to those I already mentioned? Should there be additional disclosure beyond that currently required by law beyond what I described? And whether or not there's a need for additional legislation, are there approaches to encouraging best practices in incentive arrangements the task force might look to? Those are three issues.

Now, I would note that in Steve Latham's article, and I think Steve's article is a very good one. He is I think director of medical ethics for the AMA. He indicates that there is no evidence that incentive arrangements are adversely effecting the quality of care. He also notes that quality measures are crude and that there is a time line, so notwithstanding the lack of evidence, there may be concern with one or another approach. But the fact is there is no body of evidence going one way or the other. The one area that has -- the one type of incentive arrangement that in addition to those that are currently prohibited that I mentioned that has raised questions involves an incentive for a

capitation to a primary care physician that includes the risk of referral. Latham refers to it, the Advisory Board refers to it. I think -- what's our friend, Alain, at Harvard, the expert in quality Don Berwick refers to it.

So that's a possible candidate for legislative action; although, I would note that the question would be are there offsetting and positive incentives that are included in that incentive appropriate? And one of the difficulties of legislating in this area is that if you say individual physician capitation including the risk of referral is prohibited, what about where two physicians are involved or three, and what's the appropriate panel on it? So it's a difficult issue.

Donna noted that promoting risk adjustment and stop-loss is desirable at least where there are small patient counts, and that's true the approach that the federal government took, so a policy question for us is should we extend the federal rule of California? I would note that the federal rule as it was implemented is very burdensome administratively; although, there might be ways to do it that were less so.

Latham's article criticizes the way the rule operates, but that's a possible action that the task force might consider. I mentioned the question of encouraging best practices and whether or not we look to

legislation, and if we do I would guess it would be rather targeted at the most is there a way that the task force could encourage or recommend encouraging best practices and see that played out in the marketplace? Is there a private entity that we could look to, for example, to examine physician incentive arrangements and put a seal of approval on those that do not raise ethical issues? Something for us to consider.

Now on the subject of disclosure, I mentioned that AB 2649 does require disclosure, and the question that Donna and I have been talking about is that disclosure of the kind of arrangements that the plans have entered into. It doesn't answer the question for the patient who walks into the physician's office what is the form of incentive which this doctor is subject to. So that raises a question is that important information for the patient. If it is, is that information that ought to be disclosed on a mandatory basis by the physician? If so, is there a simple way of doing it because these things are very complex, and is it something that should be disclosed -- should be disclosed affirmatively without waiting to be asked or upon request. So with that long introduction we welcome a good discussion on the issue. As I indicated, we're still in the very preliminary stages of our task.

THE REPORTER: Can we take a break for two minutes?

CHAIRMAN ENTHOVEN: We'll take a

ten-minute break for the court reporter.

(Brief recess.)

CHAIRMAN ENTHOVEN: Will the members take their seats, please.

Steve made a remark that I just want to pick up on. After our Fresno meeting I received a letter from a physician out there which was an eloquent denunciation of what he called nuclear capitation; that is the individual primary care physician being at risk, not only for his own services but for all the referral services and possibly for hospital services.

So I telephoned him, and after a little telephone tag we hooked up, and I said, "Doctor, can you tell me one example where that exists in California because I rather doubt that exists. I never heard it in actual existence as opposed to a theory." And after the pause he said, "No, I can't."

And I think that it's important for us to think of this in terms of whether it's necessary to curb abuses that actually exist and not necessarily reach out to deal with all theoretical possibilities that don't -- because there may be a lot of reasons why nuclear capitation doesn't exist in California.

I'd like to open up the discussion with Dr. Karpf.

DR. KARPF: We've heard that the previous lists of fee-for-service list that may have in fact incentive physicians to do more. We hear the fears that

the system may incentive physicians do more than appropriate, and we hear that the amount of care system capitation may send people -- physicians to be less than appropriate.

I guess the issue to me is who defines appropriate because I think that becomes a fundamental issue when one is trying to decide what is appropriate, what isn't appropriate. And maybe what we need to do is rather than regulate is start developing a body that can in fact start to define what is appropriate using the limited amount of evidence based in medicine we have, using the expert panels, and essentially defusing the controversy by trying to get on a more of what they call footing on how things should be treated and when they should be treated. Not that we have the answers in medicine today. I'll be the first to tell you that the definition of appropriate care on various medicine are not well defined and need to be defined over time, but unless we get started, we're not going to have that information.

CHAIRMAN ENTHOVEN: Right, and as you know, Dr. Karpf, UCLA has led the way on that with the grand UCLA project which is in Mark Chesit and developmental brokers distinguished people trying to develop a methodology, and what they came out with, you know, with expert panels, literature, the whole thing was that they could divide cases into appropriate, inappropriate, and equivocal. And in some cases quite a

large percentage of cases were equivocal, so we didn't have to think about that is what happens to the gray zone since we know a lot of medicine is in the gray zones.

Yes, Dr. Alpert?

DR. ALPERT: Actually, I'd like to follow up on what you just said, and that is prior to this last comment. Point being, are there any large identifiable problems that everyone agrees do exist in the system, and we should, you know, we can give opinions on those. And in my answer to that is, yes, and actually they have been there under the old system, and now they're a couple of nuances that have changed in the new system, but we now have the opportunity to address them.

I'll give you an example of one in the old system. I refer to them as a paradox, and I refer to them as paradox because the end attempt I think are things that everybody, no matter what agenda you come from or what department you come from, agrees it's not what anybody wants.

First one in the old system, we had gotten to the old system in the Medi-Cal fee-for-service system that began to replace, pardon me, about five percent of the physicians in the state were taking care of the 95 percent of the Medi-Cal population. And I don't think anybody would agree that was a good thing. Now, those percentages may be a bit off, but we actually did some surveys with county medical societies and so

forth and asked them for a list of doctors who did specialties who do take care of Medi-Cal patients. We had large cities of a million people or more where there were no physicians in given specialties that take care of these patients.

Nobody agreed that that was a good thing. There was a -- now, I put that under the incentive or disincentive rubric because it's what you are or not being paid per amount of time taking care of certain patient population.

I think Clark Kerr in his first presentation I remember weeks ago brought this up again in the present system. He pointed out is we now have a system where the doctors have developed expertise in taking care of the most difficult problems, and we want those doctors to take care of those difficult problems are essentially disincentive to do that. I don't want -- everybody agrees that that's not a good thing. That's something we could probably work on because we all agree it's probably a bad thing.

The same thing is true of hospitals that develop expertise, and we had one person testify; although, there's been a lot of people from the hospital testify about these problems, but we had one pointing out the HIV expertise recognized by the federal government so forth and so on, and the whole medical community yet can't get contracts and so forth. Well, everybody agrees that's not a good thing. We ought to

have people develop expertise. It's the center of excellence to being able to take care of those patients.

And I think there are enough of those paradoxes that exist now that we can all agree on, and if we they do come up under this kind of rubric incentives or disincentives that maybe we can develop some recommendations systemically to take care of those things and have unanimity of feeling.

MR. ZATKIN: The issue I think you're referring to or maybe the approach is involved risk adjustment.

DR. ALPERT: Absolutely.

MR. ZATKIN: And we had discussed that, and we're doing a little work to find out more about the technology of doing that in terms of the provider payment level. We haven't had discussions about it at the health plan level, and now we're looking at it in terms of provider payment. How well it can be done, and whether it's something that we should be requiring, or if there's a way to encourage it short of requirement, but it's clearly a title count of origin.

CHAIRMAN ENTHOVEN: Good point, yes. Clark?

MR. KERR: One of the criticisms of that approach was that risk adjustments are probably along, we could only suggest, about 30 or 40 percent of risks, and I guess response to that is maybe 30 or 40 percent is better than zero percent which is where we are now.

CHAIRMAN ENTHOVEN: All right.

DR. CONOM: There are a couple of experts, one at UC and one at San Diego that we've gotten publications from. Perhaps we can invite somebody in process of researching some. I believe it's extremely important.

MR. HIEPLER: Dealing with Carol and Steve's report, I'd like to just point out a few different things, and when you're talking about should it be affirmative disclosure, what should you disclose, who should you disclose it to, I have some thoughts on that.

AB 2647 came out as a result of the Chang family that I represented in a case that disclosed these capitation agreements. And in litigation we will spend a year trying to get those agreements that are basically telling the patient how their doctor's paid. We have to go through protective order after protective order, because this is the best kept secret in managed care. And it impairs us today on whether capitation is good versus fee-for-service or what's good or bad, but that is never known.

Most patients, and I don't know that it's part of our survey, they do not know how their doctor is paid. They still believe it's some fee-for-service type of situation plus their copayment of $5. So if we make the basic proposition that patients need to know how the system works, and an informed patient is going to be the

best served patient. We need to tell them how this works.

In AB 2647, begins this process to say you got to disclose, you know, how they're paid generally. But by saying you're in a capitated system, that really doesn't go far enough. And if we take the basic proposition that most disputes are best handled between the doctor and the patient if they can resolve it, if a patient doesn't understand what obstacles there may be there for referral for treatment, even those 1 in 100 types of cases, they can't ever resolve because they don't even know the system they're working in. So patients have to be informed of that basic idea in order to potentially resolve their disputes and keep them off the 1-800 number.

And to distinguish, we always hear this fee-for-service versus capitated HMO contracts, and one encourages over treatment, one encourages under treatment. But there's one distinguishing feature in that in a fee-for-service plan, and I'm not saying that's the end-all, but in that plan the patient does find out how much their physician is paid. They get a bill. They receive it, they participate, and it's usually 20 percent of that bill. But what's left out of that equation in every HMO plan that I'm aware of is how their physician is paid in a capitated HMO setting. So the patient is not equipped to ask the proper questions. Should there be that tendency to under treat.

So there's a real clear distinguishing factor there that all of this is separate, and if you did a pole right now I guarantee you would get 98 percent will be those people that think their doctor is still fee-for-service. That is part of the definition that can be concluded as a scam when someone is operating under the assumption they're getting something that they're really not. And if you ask 90 percent of the doctors, they want this to be disclosed also.

And right now as part of getting these contracts and actually seeing the numbers as opposed to the Lincoln boxes, there's primary care physicians that are getting $5 per month per patient. Now maybe that's good, maybe that's bad, but it should be able to get discussed and the patient should know that. The doctors want that to be disclosed, but are always a little concerned about who's going to do it.

And then a real problem from attending and speaking at HMO industry conventions primarily in the lawyer groups, the goal of most HMOs that are not the Kaiser-type model is to capitate the entire system, take the risk off the actual quote, unquote, insurance company and capitate anything that could happen from the slide reviewer of a cervical exam to a potential cardiologist that may be used. And so that's very important for the patient to know what if I'm having my biopsy I'd like to know who's getting paid and what. I don't want to know that that person is only getting one

cent per month for my head. Because the potential for overusing substandard people in volume review of slides we saw like this, and we see it all the time.

So I think should it be affirmative disclosure, yes, and where should it come about the HMO knows the numbers. They should allow the medical groups once the patient signs up on a capitated program there's an immediate census that is taken so the medical group knows how much money is coming in on that, you know, how many patients they have. They can tell you what is capitated, and there's different complex arrangements, but they know the primary care is capitated. They can tell you if your slide reader is capitated, if your cardiologist is capitated. It's a very easy thing. It doesn't take a lot of effort, and then at least the consumer knows for that 100 doctors that might abuse the privilege and never refer and never treat because we see the contracts that say, "you will lose money if you put people in emergency."

And in Mrs. Chang's case they asked for the emergency room ten times and never got sent in there because that was part of the contract. They asked for specialty. They never got specialists because that would have caused money to be lost, and as Mr. Chang had written in California Medicine if he had only known how his doctor was paid, they wouldn't have had the confidence that we all instill in our physicians, and they would have gone out on their own and paid for it on

their own to get their own treatment, and in her case clearly she would not have died of colon cancer. And that's not an antidote because it happens all the time. Thankfully most of the time it's not a threat of cancer that's missed.

But if we really believe what we're all saying, the patient needs to know how to understand the system, then the most important ingredient how much of me as a patient how much of my money is going to actual medical care, and from a competitive analysis I want most of my premium dollar going to the medical care as opposed to administrative costs and costs for people to keep me from getting medical care. And that's something that can put it even and open in a free discussion, and so I think it should be affirmative, and it should come out from the medical group level opposed from the HMO because that's our only angle to regulate the medical group. Because it's so important, and it's probably the most important ingredient in being able to understand and check the system properly.

CHAIRMAN ENTHOVEN: How detailed would you have in mind? What would a disclosure that you have in mind look like?

MR. HIEPLER: Well, it would say these things are capitated. Here's the definition of capitation again that's in your booklet. Most people honestly aren't going to read it. And these are the services. This is how much they get paid per month for

you. And it's very easy because, you know, they already know the ten things that are capitated, and drugs -- for an oncologist a capitated oncologist, now their capitated for drugs. They're not getting taxed on, they're not getting a lot of things when that happens. But it's very easy to just list here's the type of specialists that we have that you can conceivably see. This is capitated. This isn't. This is. This isn't.

Then the person has that power to check that person, to ask the question, you know, "Am I not getting the subspecialty referral back to my oncologist because that's a capitated arrangement or are you consequently sending me to her because she is capitated?"

CHAIRMAN ENTHOVEN: Mark, I feel very sympathetic to this idea of disclosure of material information. I am going to ask the question again because I'm concerned about the practicalities and that we don't end up with something like the disclosure that the SCC requires that's in the prospectives. And I'm sure you tried to read some of those, and after a while you find it impossible. Would they please quit saying, "This is very risky. There could be no insurance," and just get done with it.

So if I just pursue this with you a little more. Suppose you -- we created some kind of an equal space for a concise statement that is substantially correct, and it might be something like

this: "The Medicare health plan pays the doctors in the ABC clinic a fixed payment per patient per month which is adjusted for the age and sex of the patient, and they pay on a bonus formula more or less depending on hospital costs which could raise that capitation amount to the doctor group by plus or minus 10 percent.

Paragraph, next paragraph, "The ABC Clinic pays its doctors on the basis of salaries that depends on their specialty, their workloads, and their seniority or something, and also on bonuses which are related to patient satisfaction, overall success of the group, and productivity, which bonuses might be as high as 25 percent of their salary. The XYZ group refers some patients to outside specialists in their network, and they are generally paid fee-for-service or fee per case," period, end of paragraph.

Now, I could imagine some lawyers looking at that and saying, "Oh, my God," but, you know, there's this doctor that we pay that money, and there's that doctor that we pay that way, and occasionally a patient -- so it's not complete, so we have to make it complete and then pretty soon it's a complicated several-page treatise that nobody will read or understand, and I'm rather concerned about that.

Is it possible -- you see what I mean? That you can be attacked for incompleteness if you provide the information that gives you the right general reference, but doesn't have all the whereas footnotes is

my point. Consumers could read that and understand it, but I'm just worried about whether this would blow up in our face and look like a, you know, the prospective for an IPO.

MR. HIEPLER: That's the important part at the medical group level because they don't have to go into -- they could say salary, but the medical group is going to receive 2794 a month if you're in Ventura County, and that's very clear. That's for primary care physician services, and I think that's an important thing because you might get four different doctors if you're at a big physicians' medical group. But if you know that that's what they're getting and that's how they're paid, that tells you that you're in a different system, and you need to get care in a different way.

And I don't think that it begs the question that you have to go through every kind of detail. You can start and just disclose how your primary care physician's paid. This is how they're paid. This is how we receive money for your primary care, and then say upon request we'll tell you about the lab. We'll tell you about -- you could do it in several ways. That would not be onerous, but I could think of a thousand ways to make it onerous and cause more problems than it's worth. But at minimum, to say here's how much our medical group receives for your primary care, and this is what we receive for your hospital because as you all know hospitals are capitated too, $29 a month

whether they use it or not.

DR. ROMERO: Alain, let me make your question.

Let's say the worse happens in 15 years and lawyers have gotten a hold of this simple contract and turned it into a phonebook that's left on the coffee table that no one reads. How is that worse from the status quo? I mean it's clearly worse than ideal, at least for those who believe in disclosure which is what Mark just laid out.

CHAIRMAN ENTHOVEN: Well, one thing is to have generated a whole lot of cost that may or may not serve a useful purpose. Two, the thing I'm worried about next is does that become sort of a part of the contract, so it turns out one day that Dr. Smith who was doing the lab work on capitation or on some other basis retires, and they find some other doctor who for good capitation and inspect his work and they think it's good, and so they sign up there. Is this going to be considered a breach of contract? I mean how can we not, you know, freeze this?

MR. HIEPLER: I think you can say that annually, you know annually, it's disclosed here. Really, there's two or three big ticket capitated services that you're ever going to find in a normal contract. And if you outline those and say others are available upon request then you at least have alerted the person that there is this incentive out there you're

never going to see a bill. And here's why you're not going to receive a bill.

And, you know, the phonebook, even in a phonebook in the worse case scenario is there outside the cost issue, it will hinder a lot of conversations, and people will learn what they're really buying and what they're getting for their money.

DR. ARMSTEAD: Let me ask you a question because it's seeming more complex, and I'm just shooting this one back to you to the economics of really how -- if any medical group, and I understand exactly where Mark is, and I fundamentally am sympathetic to that, but let's say you're getting -- you're doing business across three product lines, so you got Medicare risk, you got commercial, and you got these dismal Medi-Cal rates that you're dealing with and treatment. And then all of a sudden you really can't give this comprehensive number this is what is for your primary care because that is not in fact the case. In fact, you need to break that out because this is really your number for your primary care for Medi-Cal, this is your number for primary care for Medicare, and this is your number for commercial. We do not want to give an illusion when you're doing eight section adjusting, and you're doing it across multiple product lines, and we have to be careful that it clearly is different factors that go into the calculations under ABC Medicare conversely for Medi-Cal.

If we're dealing with carve outs and

groups starting with rates that are $68, it becomes a very different number for a Medi-Cal beneficiary that you're telling here's the primary care rate, and here's the Medicare, and how do we administer or how do we give that signal that we're dealing with that, and that is really the reality within the medical group often.

CHAIRMAN ENTHOVEN: So you're saying you could easily see along those dimensions it becoming more complex. Every care --

DR. ARMSTEAD: Yes.

CHAIRMAN ENTHOVEN: Okay. Bruce?

DR. SPURLOCK: Thank you, Mr. Chairman.

I just want to talk and continue to talk about the theme that I brought up this morning restoring the public trust, and I wanted to expand a little bit because I think this area actually will have a significant impact on public trust, maybe not complete, but significant impact where the discussion more in my view doesn't have as major impact.

Although evidence is incomplete, I want to talk a little about bit about the issue of when do you inform the consumer or the purchaser about this -- these arrangements for incentive payments. And one of the problems I have with individual physician is that patients will continually kind of -- whether it's managed care or whether it's anything and questioning my motives. It's not a common occurrence, but on a regular basis I can remember four or five years ago a patient

coming in after I made a prescription and made a recommendation for a drug they said to me, "Dr. Spurlock, do you have a financial interest in this drug company?" And so my motives and my conflict of interest was acutely interested by that patient at that time. It was on something completely separate and my motives were the central focus of the trust of that patient over my decision and my recommendation of that drug. And I think that's an important component.

And so I would like to say is the recommendation I would make is we need to make an affirmative declaration at the time of enrollment at the time of the purchase in the explanation or coverage or wherever we want to do it, but not necessarily affirmatively every time a patient enters into the office. However, I would say that every physician should be prepared to defend and clear the air about their motives, about their medical decisions, about the things that are making them decide the things they do on a regular basis patients -- when patients ask.

Does that mean you have to hand out something? I'm not necessarily sure that's the correct answer that handing them a disclosure form about this is how I'm paid, and this is the mechanism in my bonus pool. But I think it's important for the patient to understand from the physician in his or her own words why the decisions made then on individual basis weren't asked.

The one concern I have on the larger enrollee level when you actually purchase health care is that the detail of payment arrangements $27 per month, $40 per month, $30 per month, is probably not relevant, and actually it's an infringement on the medical group or the individual physician's ability to negotiate rates. And I think that's a dramatic important right those patients have, and it's not necessarily a benefit the goal that I'm really after which is restoring the public trust.

If the public feels it's $27 with Dr. A, $28 with Dr. B, will they trust doctor group A or B because more or less because of that? I don't think so. I think that level of detail is an infringement on the negotiating rights of the medical groups and does not really restore the public trust.

So I think we need to focus on that as a goal on this issue restoring the public trust, keep it at a broad level and not the micromanaged level when the enrollee comes, and then encourage and inform physicians that they need to defend their decisions when asked about their payment mechanism and their incentives.

CHAIRMAN ENTHOVEN: Thank you.

Mark, as I understand what Bruce is suggesting is there are problems with the dollar amount that there would not be problems with the general concept of the disclosures. Bruce, is that right?

DR. SPURLOCK: The principle is correct.

CHAIRMAN ENTHOVEN: How important -- you mentioned dollar amounts. How important is that compared to just say this is what's included in capitation?

MR. HIEPLER: I think it's very important. I you think you can do a range, but when you say capitation versus my primary care is giving -- I'm not in one of those, but my argument is my primary care gets $5 a month whether he sees me or not. That's a big difference between just saying you're in a capitated arrangement.

I'm saying that the time that should be disclosed is when you sign up for a medical group or you should be able to request that ahead of time because that's one of the empowerment principles for the consumers is I want to make sure I'm with a group where my doctor or the group is getting paid for the largest percentage that's going to go to health care, and that allows people to actually compare. You know, what are the physicians getting, how are they being paid.

I think that's an important thing, especially after Carol's comments too, that you want to know because all physicians will not be equal and depending on how they pay they can't conceivably be equal.

We have emergency room doctors are telling us that, you know, "Look at how they're paid because we're not going to be on for an hour and a half

for the 1-800 number for that HMO patient when we can save the life of the third one."

CHAIRMAN ENTHOVEN: Michael?

DR. KARPF: Actually I think most patients in managed care have some idea of what managed care means. I mean they may not be able to get down to dollar specifics. You are going to get down to dollar specifics at the market level physician. You better start educating the macro level in terms of loss ratios and who they're purchasing insurance from because all they know is someone's paying a chunk of money. They're not sure what the chunk of money is. They don't know that from some insurance companies 80 percent may be going towards health care, and some 90 may be going towards health care, and from 68 and in many ways medical loss ratios will drive what happens to them and their health care to a more fundamental degree than individual incentive.

CHAIRMAN ENTHOVEN: Of course, that is disclosed for anyone who knows how to find them through the --

DR. KARPF: I would ask how many people here know how to go find medical loss ratios right off the bat?

CHAIRMAN ENTHOVEN: That's why I qualified that my question. I mean it's in the annual reports of the HMO.

MS. DECKER: How many people believe that

the medical ratio loss are comparable?

CHAIRMAN ENTHOVEN: That's a very good question because we all know they're not comparable because they're based on different accounting systems. Accounting is much a part as medicine.

Over here, oh, Michael?

MR. SHAPIRO: One of the recommendations for all of us to look at Knox-Keene Act to look at, it's an enormous amount of disclosure currently required. When we talked to consumers, they've never read their disclosures. They come to us when there's a problem after the fact.

I will caution too greatly on disclosure as a means for addressing concerns regarding potential dysfunctional outcomes associated with incentives to the extent there are systemic approaches where we can remove the need for consumers in advance. I guess the litigation issue, when you're that far along and you realize you're in a diverse incentive there. But I think at the front end if there are incentives that are too intense, and there's a consensus for individual practitioners or if you're just starting out capitation for pharmacy benefits, and among other things, and you're making these isolated decisions, but not general decisions where you can absorb those risks, I would encourage to address those in a systemic fashion, not to exclude disclosure, but simply not to rely on disclosure of dysfunctional systems and then hope the consumer is

wise enough to notice them. At that point your client had gone out to pay for it himself or herself, that's not always an option, nor choice for option. You may not have another plan to walk to. At that point on your knowledge is a fairly fearsome capitation system in terms of risk.

So I'm not advocating against disclosure. There's a lot of disclosure. You get that evidence in the big book, and people can focus on these issues only after they have the problem. So I would encourage looking carefully at the extreme ends of incentive risks, and as the federal government does maybe there are some areas where it's gone too far in terms of conflict and without giving the government significant problems I would invite you to do so.

CHAIRMAN ENTHOVEN: Let me ask you about disclosure. I think that's wise to say we go out and prevent use of ratios whether they're disclosed or not because a lot of people aren't economists and don't understand that. But this is my understanding and this is a question, because I may be wrong, the way Knox-Keene works is the health plan has to disclose to the DOC how it pays the medical group. How the medical group pays its doctors is none of their business and even how the health plan pays the medical group is not disclosed to the public; is that right?

MR. LEE: That's not disclosed to the DOC.

CHAIRMAN ENTHOVEN: Can you explain that.

MR. LEE: Yeah, this discussion I think, and the point that Mark raised which is -- I mean it's fairly radical kind of requirement that he's proposing, and I'm kind of reminded of the story of the astronaut who's sitting on the top of the rocket, and they asked him what he was thinking about when he went through the final countdown, and he said, "I'm thinking about I'm sitting on a machine that's got a hundred million parts in it's all supplied by the lowest bidder."

And when you think about it, when you buy a car, I mean the critical safety of the car is the brakes. And you don't ask, "Does the guy who puts the brakes in the car back in the factory, you know, what's the incentive arrangement that he's paid under? Is he paid by the brakes," for which might encourage for errors. Basically you want a brake that stops you.

I can see why the plaintiff's story would be interested because it's like murder. You don't have to in a murder case prove motive, but your chances of getting a conviction are a lot higher if you can show motive, and I think that's at least incentive, you know, why disclosure could be of great importance in the plaintiff's case.

I guess I would echo Michael Shapiro's comments I wonder how truly empowering information about the low level or the levels of compensation, and compensation really are to the consumer information is

both expensive to produce and expensive to digest. Knowing that the rate is $27 or $37 or a $137, those are just numbers. You have to have some context so as recovery securities are interested do a lot with drafting for specialists. I would say the context is a lot you can't just throw out a dollar and expect that to be meaningful in any sort of way.

And then finally I would say why focus on just the capitation as a incentive. There are lots and lots of incentives in any system, and I think the chart we saw earlier demonstrates that. And the incentives go all different ways. And while capitation may prove incentives are powerful incentives in some instances there may be other incentives. And even under the fee-for-service there were union incentives some of which got addressed by federal legislation, but physician partnerships, interest in clinics, and the influence that may have been through promotions, through pharmaceutical companies. There are all kinds of incentives in the fee-for-service, and there will be incentives in any system that we're offering to them.

I think it is a impossibility along the lines of perpetual motion machine to say that we're going to come up with a system that does not incentivize, so I think the focus should be on the quality of care at the low end is receiving and not so much the incentive arrangements.

CHAIRMAN ENTHOVEN: Thank you. J.D. and

then Peter.

I just -- I think of Justice Brandise who said, "Sunshine is the best disinfectant," but I think your point is really wise. There's really a whole ecology of incentives, and just looking at capitating your fee-for-service by itself as Donna's paper pointed out the impact of fee-for-service on potential for over utilization depends in part on whether the doctor is very busy, in which case he can make a very good living without over-utilizing or the doctor has a big shortage of patients which he has a big incentive to over-utilize them.

There are all these -- and then there's the incentives that comes from the interaction within the group. So it's true that there are a lot of other incentives that are important to the economy, incentives including professional incentives.

Doctors all want to be excellent and esteemed by their peers and appreciated by their patients and so forth. So that's true, good thing to think about.

DR. NORTHWAY: One quick comment on that positive incentives which you show who paid the doctor groups Mike might not, might be shown how poorly Medi-Cal pays in regard to commercial, and so there would be some incentive to bring those rates up so use much caution going on.

On the other hand, if you do that, you

also might have a negative effect on the commercial payers who go to that provider because they're using some of my dollars to take care of some Medi-Cal patients and not to talk about before 95 percent of writers are taking care of disadvantage, so they're obviously --

CHAIRMAN ENTHOVEN: To the extent that disclosure is required, it prohibits people from doing things that they don't feel would be compensable.

All right, Peter?

MR. LEE: A number of points in terms of what Mark said rolling around. A couple very important, one is he's raised the point of group level -- medical group level, and I think that's incredible. We keep coming back to different ways to regulate health plans, but the incentive arrangements that matter are generally not health plan level. They're at a level down. And how to get disclosure at that level, whatever the disclosure is, I think is an important part of this conversation.

Second, I absolutely agree we should be talking about not just capitation, but the range of setting of arrangements. Whether we have specific numbers or range of numbers, I think it is important for groups to understand there's different ways people get paid. Capitation is a way. There are bonuses. There are withholds, and part of educating consumers is many systems have changed. It's not just you get money on

the table. There's different mechanisms in play I think is an important part in educating consumers.

I think back to the best practice idea. There are some medical groups that are doing very creative things about incentivizing good doctor-patient interactions that are rewarding satisfaction and some of those are noted in here. Those are upsides that I think they would love to know about, and I think they generally don't. You know, how do we need them and how we as a task force share in the best practices is very important.

The last is in terms of Bruce's note about the infringement on negotiation rights. I think that, I mean, I think having access to the information about pricing makes the market, I think from the little I know of economics, work better rather than have it hidden.

And one of the things that happens today in terms of a lot of our discussions, a lot of what we know about what does or doesn't work relative to incentive arrangements, we don't know because it's very hidden. And what is submitted to the department in terms of incentive arrangements is, as I understand it, about the health plans, not what the health plans pay to medical groups, but that's not public; that's the department. And that's not information that the public, regardless of whether it goes to all consumers, is available for scrutiny to say, "Let's try to analyze how

many times in California our individual physicians did an individualize cap rate with a bonus."

And, Alain, you sort of noted that, "I don't think this is really happening." Mark then noted, "I've seen it happen," and our little survey in 1995 notes that six plans hale individual capitation basis.

I'm not sure how much is happening, but without having some detailed information available that is open to scrutiny, we can't have a better understanding of how much financial incentive may be effecting quality. And that's one of the broader charges that I think we need to sort of make sure we have a charge of future investigation and try to answer the question about what is the relationship between incentives and quality care.

CHAIRMAN ENTHOVEN: The six health plans, that may be capitation for primary care services only, but it may not be nuclear capitation.

MR. LEE: It may not be, but that's part of --

CHAIRMAN ENTHOVEN: Right. Berwick has written capitation for your own primary care services is really like a salary that depends on how many patients are on your panel.

MR. ZATKIN: Alain, there are three approaches to capitation that -- actually four. Capitation for the service that you provide, capitation for those services and the risk of some referrals, full

risk capitation which if you try to do it puts you in a position of trying to get a license I think at least a sublicense, and then capitation for specialty care.

And in terms of what's going on in California, I think full risk by definition is not supposed to be going on. But capitation where you assume the risk of at least some referrals I think is, and that is the area that at least raises some issues that I was --

CHAIRMAN ENTHOVEN: Individual capitation at risk for some of the referrals?

MR. ZATKIN: That's correct.

CHAIRMAN ENTHOVEN: Okay. Yes. Okay. Bud? Oh, okay, I better get the left side of the table. Let's work over here. Sorry, Jeannie. Okay. Jeannie Finberg?

MS. FINBERG: I wanted to go on record as saying I think disclosure is critically important, and if one of the goals, as Bruce said, is to restore public confidence, we can't do that without some disclosure. And I think it's really a question -- I agree with Michael that disclosure doesn't solve all the problems and to the extent that we can agree on financial incentives that are harmful, we should physically outlaw them. And I would welcome that discussion at that level also.

I think that Donna and Steve did a good job of outlining the issues in this area, and I think we

should go through each of those questions that Steve raised and formulate our answers to the extent that we can agree or agree to disagree about them.

With regard to what is disclosed, it is a conflict area. There's no question about that in terms of the many permutations of financial arrangements that can exist. They do, however, fall into certain basic types of arrangements, and some of them are described in these charts. I think that -- I'm not sure if the exact numbers need to be disclosed or not. They could be ranked, but there has to be some way for people to compare and to evaluate the incentives that are inherent in those arrangements.

And the Department of Corporations does receive the information about the health plans. It has the expertise potentially to do the ranking and dissemination, but they do not disclose their evaluation process or rankings to the public which I think is necessary. Also the missing piece of information of the medical group must be disclosed.

So I would not -- I think it might be possible to have the Department of Corporations rank these types of arrangements or to have certain types of minimal disclosure. I do think it should be at an affirmative level to all enrollees, but then as Mark described, maybe there are certain things you could get upon request. I know consumers' union couldn't get the necessary information to try to evaluate financial risk

among plans.

And I like the car example that Keith raised because, you know, in consumer reports evaluation of cars has been respected for many years. We have a lot of data that we've been able to collect very successfully to disseminate to the public so that they can feel very confident when picking the car whether or not it has the good brakes. And we can't do that with the health plans or the medical groups. But if the appropriate information were mandated about financial incentives, we would begin to get that information. So although disclosure isn't -- it doesn't tell us everything we need to know about quality, it begins to tell us some of the information we need to know about choosing one plan.

CHAIRMAN ENTHOVEN: Thank you. Clark?

MR. KERR: I think disclosure is a no-brainer as to the questions what to disclose really, and we can talk all we want. It would be fun to kind of ask the public what they maybe want, but not to hear per se find out what's of interest to them. We can speculate to the quality or whatever, but it would be interesting to find out and ask specifically with the PMPM dollars. It would be interesting to know if the medical loss ratio is more important. We could get a standard approach which is the actual results.

Going back to Keith's example about the brakes. Consumer brakes are very important, but it's

not the incentive arrangements and so on. It's how many feet it takes to go from 60 to zero, that for me results in the criminal thing. And it would be wonderful if we could sort of get the sunlight on the situation and make it such that we buy it sort of exposing what the incentives are and make sure the incentives are getting good quality and getting good results. If you came back to sunshine, it's what you want, it's not necessarily what you pay, it's what you finally accomplish in the interest of patient incentive.

CHAIRMAN ENTHOVEN: Allan, I thought you had your hand up. Ellen?

MS. SEVERONI: Yeah, I agree with Clark on disclosure, but I am one that at some point I've done -- can't do it. I'll yell. It's picking up.

You know, some of the work that I've done with my own family who are now members of the managed care environment is to have them ask the physicians specifically, "Are there choices or options for my treatment that you are not offering me now because of the relationship that you have with health plan or because of the type of which I have?"

I guess what I'd like to focus the conversation just briefly back on is really how powerful it is when we have an informed consumer asking her physician whether or not she is withholding any kind of treatment because of payment. And that what I'm hearing back from family members and others who have been doing

this is that it's somewhat of a shocking question that physicians aren't used to being asked, but it has overdone the level of dialogue.

I don't know whether or not it's the answer, but I know one focus might be helping consumers frame questions. I wouldn't know how to advise someone whether or not 27 or 30 dollars is appropriate or not. But it might be a little bit simpler to try to get people to think about asking physicians whether or not certain services are being withheld because of a contract they have or a relationship they have with the health plan that might help us get to that on a more personal level.

And I guess one of the thoughts that I've had about this governor's task force has been I would like to see us formally encourage health plans and others in this state to look at a Managed Care 101 kind of course.

I'm not sure that I agree with you, Dr. Karpf, when you agreed that people are pretty knowledgeable about managed care. I find people willfully not really good at knowing what their managed care plan offers until they get sick, and then all of us sort of frantically looking through those booklets, and what is it that it has, and how do I navigate the system.

I still think that here in California we really do need a Managed Care 101 and I envisioned it

something like our wonderful tobacco education plan where we're using a variety of PSAs. We commit to education over a period of years. And I'm hoping that we might be able to come to some sort of agreement that we would like to recommend in a sisterly and brotherly fashion that be something that we take on by the plans and others of the industry here in California. As you know, not something that has to be regulated, but something that could be done together and would benefit all Californians.

CHAIRMAN ENTHOVEN: Bruce?

DR. SPURLOCK: I just want to make a quick point about medical groups. I've heard a lot of discussions about medical groups, and I'm in a medical group and an awful lot of doctors are in a medical group.

In California the average size of medical group is between five and ten physicians. So there's a lot of discussions about what you think a medical group is and how they pay themselves and how they negotiate rates. There are the big ones, Med Hundreds, Toullet, Brown and Toullet. They're the mambo-sized medical groups that have very intense structures and incentive mechanisms and bonuses and payment schemes. And, in fact, one IPA, Lakeside IPA, down in Los Angeles is simplifying their payment scheme because it turns out in their experiences physicians don't do very well and don't modify their behavior very well whether they have

a very complex scheme.

That notwithstanding, I think it's important for this group to be able to talk about regulating a medical group or finding out the information of a medical group, just how many doctors are we talking about? What size the medical group is, and how much these four physicians actually allude or go to something on all these issues.

CHAIRMAN ENTHOVEN: Okay. John, you had your hand up. Let me just say I'm getting a little concerned about the time because we wanted to spend some time -- on the other hand this is such a great discussion I feel like we're learning a lot. Should we just keep going? Okay. Where were we? John?

MR. RAMEY: We talked about incentives, and when you think about over half the employees in the state don't have a choice of health plan, that many groups that they go to is more likely to be driven by the incentive that the agent has in marketing whichever plan it is that they're marketing. And that that might have more fundamental -- I mean disclosure of that payment mechanism might have a more fundamental impact on who gets to see whom than disclosing how much physicians are receiving on a capitation basis. Like which car you're going to buy dependent upon how much the car salesman gets paid.

CHAIRMAN ENTHOVEN: Right.

DR. NORTHWAY: Yeah, I'm sitting and

listening. I hope you all don't think that because somehow we're going to disclose that somehow that's going to take care of the problems or that with all due respect Managed Care 101, it sort of outcomes 101, and that's what people should be making their decision on what kind of outcomes do they get with the health plans that they're involved? And how soon they get paid in reality is nothing. If we invested the only thing in somebody is how they got paid, and we don't try to move towards outcome, I think we've wasted a lot of time and so someone 27 PMPM versus 25. What the hell does that mean to me? I can only speculate.

CHAIRMAN ENTHOVEN: You're right. This is not a fantasy or anything else, but if you say what's new and different about managed care before that's causing suspicion and concern, there is a lot of focus on the capitation incentives. And it just somehow seems if we could find a simple way to do it that didn't go the way of the prospective --

DR. NORTHWAY: I don't care if you tell somebody --

CHAIRMAN ENTHOVEN: Yeah, just to clear the air. Okay.

DR. NORTHWAY: Don't stop there.

CHAIRMAN ENTHOVEN: Yeah, absolutely.

DR. ALPERT: I think the paranoia about what awful things might happen if everything was disclosed down to the final detail is unjustified, and I

think history proves that in other areas. I think that if you look at the Physician Desk Reference which is in every doctor's office which concludes you can die on anything less, taking any drug in combination with that drug, all of the information is there. People take those things every day. Most people don't use them, but they're not afraid that somebody is legislatively protecting them from themselves by not disclosing having that information available. And simply the idea that they know it's disclosed and they trust the interaction with the physician.

Same thing was shown -- you know, the medical profession used to be individuals, and now because of change of paradigm, that phrase has taken a different institutional sort of compound. Has always rightfully or wrongfully lived under this sort of criticism that it fails to disclose lots of things and doctors don't tell us everything else. Everybody from the institutions aren't telling us everything.

In Massachusetts what they did when they were having a lot of pressure in the governor's office for disclosure, virtually every complaint that ever came against a physician of the state and regulators, and then a bill actually arrived on the governor's desk, and the masters of medical society said, "Don't sign that, and we'll come to a good disclosure thing. We'll tell the public more than they know now." And they did what Clark said, they went to all these focus groups, and you

know what they found when they asked people, "What do you want to know? What do you want to know, where your doctor went to school? Or how old they are," and this and that. They got to know a practice and what the doctors were afraid of and explained it, "Well, you know, lawyers do that, and that's the governing a lot of stuff."

So the public was pretty cool in handling information that the physicians thought was going to be inflammatory and so forth and so on. I think if you had a book like the PDR that said every detail, I mean Mark is saying that people deserve to have an answer how much are you being paid for this encounter, the idea of withholding that from somebody is absurd, and I don't think there should be a big fear of disclosing that.

If it has to be so involved as to explain the whole culture of ecology, and I think Mr. Bishop's point is correct in that way, maybe it has to be in something like a PDR. But something that exists and it's all there that we have access to, so the fear of being withheld and being legislatively protected from yourself by a big brother, whatever it is I think is much worse than the action, itself.

CHAIRMAN ENTHOVEN: Right. Rodney?

DR. ARMSTEAD: I'm just going to get to a couple of areas and kind of go back. I think the point I was making about the differing populations was a function in fact that I think at the very least if we

try to get into something more specific like numbers it's going to be a very complex chore.

Let me first say, that for 12 years our experience in Phoenix when we looked at managed care in that regard in which everything was pretty much an East Coast relative to an IPA model in which the primary care physicians were only capital my primary care services, and everything else was paid fee-for-service by the insured evidenced exactly what Berwick said that in fact those providers we looked at them as medical directors had the most problems were those specialists who had the fewest referrals, and often were doing procedures on individuals that had the most complications.

So, in fact, when you went back and evaluated even their credentials that you would find that even appropriately being credentials that they were not necessarily appropriately credentials to do procedures as often as they were doing. So there is a lot of evidence to support that.

The second piece of support what Bruce says as far as our plans of experience that the majority of our contractual relationships are shared risk. In fact, we will only entertain a group's request to be considered for full risk if they meet a lithium test. Now a lot of this has transitioned since I've been there, but the bottom line they have to meet a fairly stringent list before they even go.

The truth of the matter is most are not

in the critical sense in which administratively being automated to be able to deal with the whole issue incurred to understand that complexity and be able to pay and pay timely with the new constraint find cannot do that. Thus, they do not get a full risk contract, and to that end our only full risk players are med partners which used to be, you know, the breakdown numbers and one other group will pay. So if you look at that, that is really the reality that most of our patients are distributed amongst groups of the size that Bruce has articulated, and we don't have a problem about partial risking which we as a plan handle all the functions for them administratively. And I think that's an important issue.

The third piece is as we look at this, I want to make certain that we don't leave a group out. And what I mean by that is that if we talk about fee-for-service, the explanation of benefits that typically has gotten mail generally has gone to our commercial customer or medical beneficiary.

The Medicaid patient typically in a sense never really understood that California when you look at the 1993 Kaiser Commission on the average amount of dollars spent on AMC population was third from the bottom. Now that doesn't necessarily mean that the health care was third from the bottom. If you can quantitate it, it just meant that for whatever reason there weren't a lot of dollars spent on the average --

of all states, I'm sorry, I meant. So two states were below it Mississippi and Alabama or something like that.

The point is we're driving this fee-for-service, low payment which beneficiaries had no knowledge of what the doctors were getting paid anyway in which now physicians are really seeing patients because what capitation has done in a prepaid sense has brought a block of dollars on the front end although they may not be managing well that represents a revenue source in a survival sense that was not necessarily case in the past in some circumstances. So it is so complex relative to what the payment structures have done is converge, to merge and converted from fee-for-service for managed care.

I'm very sympathetic to disclosure. I'm concerned that there has never been an equal playing field of what we're going to be disclosing if we're trying to do something that is a general type of disclosure for patients so that we're not, you know, having, you know, a large document that's trying to explain, "Well, this is a Medicaid patient. This is for your Medicare patients. This is for your commercial patients," but is for your patient or consumer who is a health consumer in the state of California. So I just wanted to put those issues, and the final thing is we need to not make the mistakes that the federal government did in the 1876 law or, you know, not the -- what was the other law, Alain, not to risk, but whether

the HMO Act for Medicare came in 1876?

The problem is they dropped the 50-50 end proxy for quality. Now that was the best that they could do, and we just want to be mindful of the fact that there has been experience of trying to put something as a proxy for quality that was really there and was really nothing to motivate anything new relative to, you know, what really should be used to measure and look at. So we just want to be careful that we don't drop something here, that is a number that gets grasped on and it dilutes all of the other positive activity that's going on and really try to put something very valuable and tangible to the measure of quality and which is really I know we're trying to do.

MR. HIEPLER: And this is just basically addressing some of the comments I think that you can't ignore that people fall into two categories. Basically you believe that the average person, including me and you, can figure things out when they're giving the information or you just believe that everything is above everybody because here we sit as a bunch of experts, and I take the first position you give people information they're going to make wise choices. I know philosophically maybe people are different. That's why I think what is the most important consumer purchase that anybody makes in America; I think it's health care. And what is something that we do understand? We do understand dollars. We do understand how much someone

gets for something, and it's a very basic issue. It's not intended to be a cure-all, but we don't have outcomes, and we may never have outcomes. Those are much more difficult, but we do know how much of my $120 is going to a physician. I think that's something that is though basic, it can be accomplished.

Secondly, maybe one of reasons I have more concern in these areas than any of you, I don't know how many of you have seen one of these medical group's contracts with the Department of Corporations with the blank numbers. We tried for years getting those numbers filled in, and the until I win the verdict then I can talk about the numbers. So if you see those things, and if any of you are with companies that can show us those, I think it's important that you all know what we're actually looking at, and what brings about this discussion of concern as to why the discussions are important.

Thirdly, if you talk to physicians who are out there practicing, not involved in this, they don't want to have to tell Mr. Jones, "I'm doing the best I can for $5." And this is in reference to Mr. Bishop's reference about plaintiff attorneys. Well, just from my heart, you know, I think you know how I got involved in this whole thing to begin with.

Secondly, by disclosing fiduciary duty, you're going to take me off all the talk shows I'm on, and you're going to take all the publicity away from

these cases because fiduciary duties is something we put in all of the actions. I'm giving up a very substantial part of my practice with that. I don't want to see these people thinking, "if I had only known, I would have done something different."

So from that standpoint the thing that I'm advocating is my wife's firm and my firm's potential business. And after the fact that if they had known these things, they contend that they would have made a difference. And again I have confidence if you give them information, they'll use it appropriately. And the most fundamental thing people understand is dollars and how much they're getting for a service. If you give them that, it will invoke all the decisions that we've had that are very, very informative that can be potentially life threatening if they don't know. I didn't mean to sound defensive there, Steve.

MR. ZATKIN: Let me try to summarize and wrap this up. There obviously is a lot of interest in disclosure. We indicated that as an option. I think we'll need to focus on a number of issues, one is disclosure of one level. I didn't hear too much discussion of whether disclosure and physician -- individual physician level was important, but I happen to think it is because I think that's the practitioner that you're dealing with, and that's where you probably want to know the most.

The issue of numbers, dollars, is

obviously a very challenging one. On the one hand, there are some -- I think there are some proprietary and competitive issues that will have to be discussed in principle. Anyway, we'll have to see where that falls out.

And then there's the question raised about how meaningful the numbers are Medicare risk pays on an adjustment basis and compare that to Medi-Cal numbers and commercial. And there's an important points and we want to consider them, but I think the point about affirmative disclosure, that works pretty clearly if you're dealing with entities. If you're dealing with individuals, it's a more challenging point. So if there's an issue for individual physicians disclosing, the question is should they do that affirmatively if they were asked.

Going back to the questions that got less discussion and I think is equally important, Michael's point if there are things that are going on that shouldn't be going on, then there's an issue of protecting patients. We really didn't get into that issue very well. There's a question of fact as to how much if -- is capitation with referral going on or not. If it is, we'd like to know how task force members feel about that because all I did was cite what three or four people say about it. And that's certainly not the last word.

In terms of best practices, we are very

interested in that because we know we can't micromanage or shouldn't be micromanaging an area that's complex and has changing incentive arrangements. On the other hand, there may be some way of promoting things that we believe as a group are things that should be promoted, and so we need to look at that further. But I do want to thank on behalf of Donna, you can thank people too, but for a very good discussion, very helpful, and we will use this information and come back with more developed thoughts.

CHAIRMAN ENTHOVEN: Thank you, Steve. Donna, do you have any closing comment?

DR. CONOM: No, I agree. This is the first time we really had a chance to discuss anything, and I appreciate it.

CHAIRMAN ENTHOVEN: Yeah, this was great. All right. I don't feel quite as ironic as Steve. I think we may be able to find some common ground here. If we don't insist on everything, maybe we can get a large step forward. Like the Russians against the -- saying the better is the enemy of the good, so at least we'll go for something good here if we can.

I wish or I would like to spend some time on the Dispute Resolution. We also wanted to do something more on New Quality Information. Could we come back to Dispute Resolution? Do people want a break first?

MR. LEE: When do you want to come back?

CHAIRMAN ENTHOVEN: I'm just trying to figure out what do we want to do? I mean, we could -- you feel you could use the time now with the group on Dispute Resolution?

MR. LEE: If we're going to end at 4:30, we have a number of issues that we think can be explored more, and this discussion we had is an indication of the opportunity to get into things and I think we can. And I think it was our take that we just started discussions and really had foreshortened the meeting in Los Angeles. I'm not sure of how much of a narrated discussion we can get into the three issues we wanted to raise, and if we're ending at 4:30, so that's my concern.

MS. BOWNE: Why don't you start, and it will be so thrilling we'll all stay.

CHAIRMAN ENTHOVEN: Do you want to -- Jeanne?

MS. FINBERG: I wondered if we could talk more, put it over Dispute Resolution, so we could give it the time it deserves and maybe talk about process. Because it seems like this discussion around incentive issues was very valuable, and that maybe we could talk because, like I say, I think it's really helpful to lay out those questions that are maybe the most important or most provocative for discussion, and I think that I'll try to do that, you know, for our specialty group. And I'm wondering if people agree that we should approach each individual area that way and try to allow time

blocks of time for discussion?

DR. ROMERO: My recommendation to the Chairman a moment ago was I've experienced spending a lot of time on a given issue seems to allow us to get done we wish to do. And, therefore, my recommendation was rather than try to cram two ERGs into a small space, we give one a reasonable amount of time, say half an hour or whatever it takes, and then we come by consensus determine whether we want to extend the time or not.

CHAIRMAN ENTHOVEN: I think that's consistent.

DR. ROMERO: Does anybody strongly disagree with that? Then I think if I heard you correctly, Mr. Chairman, I think you wanted to recommend that you do New Quality Information Development and defer on the Dispute Resolution?

CHAIRMAN ENTHOVEN: I wasn't sure which way to go on that. Are both of you ready to go?

MR. LEE: I think we're ready to go with a number of issues. I think that half an hour could allow for some exploration of them. I'm not sure. We could probably use longer I guess. Barbara?

CHAIRMAN ENTHOVEN: Are people good for another half hour and then quit? Should we do that? Well, let me propose that we say we'll spend a half hour on exploring one of your issues, and then we'll call it a day, and then we'll come back to that and call it new information. All right.

MS. DECKER: I wanted to do some of the textual stuff, and I'll do it real fast, and that is we've been gathering information in various ways. And we've had a discussion in a previous session, we came up with some tentative recommendations that we're looking for your reactions to. And as we worked through it, we really found several things that have probably thought once with the most tension around, ones that were most concerned about, "Can we really get to a common agreement, something that we can all live with and afford with?"

So I think we'd like to spend our few minutes now talking about consistency, and the reason we're interested in consistency is that in our area Dispute Resolution, we think one of the challenges and problems are that the consumer doesn't know how to navigate the system. There's too much variation in how things are done in different plans, and how people change plans, employers change plans, people move, et cetera. So there's always change in their lives about what they're trying to deal with, plans change their procedures, et cetera. And then it becomes difficult for the consumer to figure out how do I get through this process. If they are seeking help from others. You can spend a good chunk of time just trying to figure out what they've done so far or where they are in their own process just to try to deal with the issue.

So in trying to think about consistency,

one of the first challenges is how do we feel about having consistency across different plan types, so here I'm talking about HMO service plans, PPO, and those plans that are E.R.I.S.A. sponsored. And of course as an E.R.I.S.A. sponsorer, I have a real difficulty of thinking how we can do things that will go that broadly. But at the same time I spend a lot of staff time in my own organizations dealing with problems, people that can't figure out how to resolve their complaints.

Some of the key issues we hear about or have perceived is in language, the ability to understand where people are in the complaint process is a challenge because every organization uses somewhat different terminology. We've looked at the health plan information that we got from a number of organizations, and we found different terminology used in each one. An inquiry, a grievance, a complaint, an appeal, all kinds of different words meaning different things to different folks. We think the timing is real different across organizations.

HMOs seem to have the 30-day requirement for responding; that's real clean, but in E.R.I.S.A. plans there's a 60-day requirement. Other plans that are not regulated the same way will have other variations. There's also a lot of difference in how long a consumer has to voice a complaint. Some of the plans have indicated there's no statute of limitations and will be four years out. E.R.I.S.A. plans can be

much narrower I believe.

Then we think that this variation causes problems with being able to compare information across plans. The things that are filed with DOC we kind of wonder in our minds if that is really comparable. It probably is, but maybe we want to extend that comparison to plans that are not covered by DOC regs and be able to look at issue by category, and be able to issue quality techniques across board range.

So the other thing that came to mind is Peter and I and Sara and Matt talked yesterday was also the ultimate recourse you might have about a complaint. Obviously in the DOC governed plans there are legal remedies coming on if you sign binding arbitration entered plan, Medi-Cal or Medicare have external review processes which can end up with an ALJ hearing. The E.R.I.S.A. plans that you go to the employer, you can go to the Department of Labor, you can go to the federal court system. So again there's a lot of different resources that are available outside the plan.

So we are interested in your reactions about how much willingness there is to say that consistency has a value that improving the definitions of having common terminology, common standards, expert plan types, different types of organizations, has something that's worth working towards achieving, worth asking for even from a legislative remedy or voluntary compliance or some other way.

So your comments?

CHAIRMAN ENTHOVEN: I'd like to answer let me think about this. Who does the lack of consistency burden? Is it the reglating plans that have to deal with several different processes? As the consumer only deals with one plan, so who suffers from this inconsistency?

MS. DECKER: Actually, the consumer does suffer because when they're trying to figure out how to do something because they might have been in a different plan before, they don't know how this plan works. The navigation is a challenge, so then when they reach out for help from another resource, could be coming to my staff saying, "I'm having a problem." We spend time trying to figure out what they've already tried. We don't know where they are in their attempt to pursue it. And when it comes to choosing a plan, the lack of good information across plans about how successful they are in resolving complaints in a very timely manner, it's not there, and it's something that I as a consumer I'd like to know. I'd like to know how much effort plans put into resolving complaints, so they never become a grievance or whatever, complaint.

MR. LEE: A couple other reminder points of what we presented in L.A. is we quickly went through a number of essential elements, sort of a measuring stick against what we're trying to look at resolution systems. And some of them noted resolving issues at

lowest possible levels. Others were fairness and perceived as fair in terms of treating consumer complaints. This is one of the other issues where consistency is, depending on what plan you're in, you have the exact same circumstances, but very different procedural remedies or in the last note the substantive remedies, and then again the major culprit or hero in this is E.R.I.S.A. in terms of people in E.R.I.S.A. plans have very different remedies available to them if they, you know, follow the path all the way to the end, and so that's one of the major questions we had.

DR. SPURLOCK: I think, Barbara, the analogy -- I think you're asking us to come up with -- potentially asking us should we come up with the best practices for Dispute Resolution. I mean it's an analogy for the medical role of best practices clinical procedures. And I guess to answer that question, if we were truly to answer it, exactly what you said earlier, you'd need to know what the outcomes are to know what's best. You need to know what the problems are, what the outcomes are, and then you'd say these the are the best practices. Working within the parameters you may want to go outside of that guideline on development of consistency.

So ask that information, I have a tough time answering the broader question should we make a recommendation on best practices for Dispute Resolution that would be consistent because I'm not sure I

understand the other very important information to recommend what's best.

CHAIRMAN ENTHOVEN: Yes.

DR. ARMSTEAD: Barbara, this would be helpful for me. Let me just give you a reality with the HIPC, particular issues they're very, as you know, they're one of their biggest areas of where they do a lot of their review as an area of appeals and grievances and complaints, and I guess in understanding the best practices. You know, I'm trying to realize the reality is I don't know if they would ever believe that if we ever got to a point where we were dealing with complaints so well that we weren't having any grievances, they would think something's wrong. And so I'm just saying that to say that maybe a reality is that there is in the context of this, you know, an expected number of grievances or appeals that you just have to deal with. And so that's just kind of what I'm trying to understand, you know, you don't know necessarily if somebody's missing something in the system if they're not picking up if you're not recording adequate grievances appeals there, is a system missing stuff? And so even in the way it's kind of done now, you know, these are just some of the challenges that, you know, that we have in trying to get them to realize that from what we can say is the best, we can do. But again, there is this belief that there should be some element of baseline appeals, grievances, not that I disagree

with that, but what the ratio that it should not exceed, something like that. So that's a reality that we struggle with.

CHAIRMAN ENTHOVEN: Jeanne?

MS. FINBERG: Yeah, I think it would be helpful to recommend uniformity and minimum standards. I'm not sure how we get there with as you say the different rules for Medicare, Medicaid, and E.R.I.S.A. plans that we possibly can't regulate. But I don't think there's any question that it would be better for the consumer and probably for the plan groups that have one type of system with uniform language and minimal requirements in terms of resolution at least by next day, that sort of thing.

CHAIRMAN ENTHOVEN: Yeah, I think I am very sympathetic, Jeanne. I was chairman of a medical committee, it was one of the big efforts at Stanford to get things simple enough so the other professors could understand it. It just helps a lot to have standard terminology so people -- they can't talk to each other if they don't have a, you know, standard terminology and some common standards as to what it means. Clark?

MR. KERR: I agree with Jeanne that a uniform approach makes a lot of sense. I think it's also important that the task force action be adhered to. Certainly that testimony from Harry and some others that we've heard from, if you set 30 days or a 120 days, it may be taking years before it goes to work, and so I

think it's absolutely critical to have standards, but also has to be meant where there's some sort of penalty for the folks that don't do anything because right now it's ridiculous what's going on.

CHAIRMAN ENTHOVEN: That is some people see standardization uniformity inhibiting freedom, but a certain amount of that is liberating. And I feel liberated by the fact that we all drive on the right side of the street, and stop at stop lights. I'd have a hard time driving home tonight if we had complete freedom of which side of the street you drove on and whether what the red light meant versus the green light. Is that helpful?

MR. LEE: I'd like too palm this a little bit in terms of the PPO side of things which is that those that are -- agencies providers regulated by the Department of Insurance have different standards right now than those that are in Knox-Keene health care service plan, and that's one of the questions that people do -- some of the them have different standards with PPO than going to an HMO. Responses to that one, I think there's some inconsistencies too.

CHAIRMAN ENTHOVEN: Self-funded or insured?

MR. LEE: Insured.

CHAIRMAN ENTHOVEN: Clark?

MR. KERR: You have to take the best one there is. I think you have a good opportunity from the

industry standpoint and information standpoint whether the patient has HMO or whatever they choose there ought to be a consistent way to deal with it.

CHAIRMAN ENTHOVEN: Well, Clark, can I just try a contrary view to joust a little bit on that?

MR. KERR: If you want to be wrong, sure.

CHAIRMAN ENTHOVEN: I would think of it as a very substantial accomplishment if we could accomplish that across the HMO industry if we could do there than to reach out to these other entities which are more complex and work differently and everything else. And market trends being what they are, you know, I'm thinking in another ten years we'll be close to wall-to-wall HMOs.

You know, we had some discussion about how much intentions do we pay to indemnity insurance? Well, it's only like 7 percent of employed Californians and their families are now in indemnity insurance and that is declining. So at least you might consider a cost benefit tradeoff there and how much resources you want to put.

MR. KERR: I don't disagree with you at all. We ought to do at least the HMOs, but let's do as much as we can.

MR. ZATKIN: My thought on this is that having worked for legislature and seeing how sometimes these things get started, sometimes there's no weird reason for the difference. It was negotiated, but

sometimes there is. It may have to be characteristics of the organization, so what would urge you is to look at the standards and the differences, and if you can't discern a rationale that relates to the nature of your organization, then we'd look at consistency as a goal.

MR. KERR: But I'd always put the patient before the organization.

MR. ZATKIN: I didn't say not to do that. I said within reason. Look at the reason for the difference. It may have to do with the characteristics of the organization, maybe because they have such a broad provider panel as a practical matter they can't deal with the issue; that's all I said.

CHAIRMAN ENTHOVEN: Okay. Any other comments on that?

MR. LEE: I push one more. I'm just trying to use up our time --

CHAIRMAN ENTHOVEN: This is good stuff.

MR. LEE: One of the harder issues both to do anything about is the substantive remedies available in E.R.I.S.A. so this task force does not have the ability to decree federally E.R.I.S.A. is going to change. However, for consumers who are differently situated, they've got very, very different remedies available. The procedures often in California being very similar depending on what sort of E.R.I.S.A. plan people are in. They might be similar, but the remedies in the end are very different. I'd be interested in

people's comments on how we should weigh in on that issue.

CHAIRMAN ENTHOVEN: It's not out of the question that the task force might recommend --

MR. LEE: Absolutely.

CHAIRMAN ENTHOVEN: -- upstream, I don't know, but recommend to the legislature, let the legislature petition the Congress.

MR. LEE: Absolutely. I think that can be very appropriate.

CHAIRMAN ENTHOVEN: Because that's certainly on the table.

MR. KERR: I would even recommend it to the Presidential commission.

CHAIRMAN ENTHOVEN: In fact, I'm glad you raised that, to say I've been thinking that we may want to make recommendations to other people also. We might instill out of this a number of recommendations to the managed care organization like hire nicer more sensitive friendly people to deal with these complaints, for example, or whatever, and I don't know to others. So that definitely should be in our possible scope.

MS. SKUBIK: The President's Commission is going to be meeting -- the President's Commission is going to be meeting on the E.R.I.S.A. issue in Chicago on the 9th and 10th of September, and they actually called the other day to ask about some California representation there to get a big state to talk about

the challenges that are posed there. Alain is going to be checking, and Phil will be unavailable. I'm going to go to monitor the meeting, and I would encourage any of you all who are interested in this issue to also go.

MS. BOWNE: Just to comment on that, there are also a number of large E.R.I.S.A. plans who have been invited to testify, so hopefully we'll hear a balanced view of that issue.

MS. SKUBIK: I don't think they actually figured out all of the coats who are going to be there.

CHAIRMAN ENTHOVEN: I don't think we'll get consensus for some kind of wholesale overturning E.R.I.S.A., but perhaps a few selective modifications here and there.

MS. BOWNE: Well, there has certainly been ample precedence said in the federal legislation last year the benefit mandates to E.R.I.S.A. plans, and certainly the Congress has found an easy way to amend E.R.I.S.A. legislation amendments to certain statutes, but I would also suggest back to you that at a certain point larger employers can say, you know, and maybe this is what some people want out of this system, "Thank you. I've had enough. I have other things to do with my dollars."

And the whole rationale between the E.R.I.S.A. plan is that larger employers generally speaking, not always, take a responsibility for their employees where they want them to have good benefit

plans. They hire people like Barbara Decker and her staff to help manage them and arrange them. Now there are bad apples. There are things that need to be changed, but generally speaking the E.R.I.S.A. plans have done a pretty good job, so you have to be real careful, you know, where you push what. That's not saying there's not room for change, but it's also recognizing what you're dealing with, and quite frankly I would say to state legislators, "Don't be so sure about what you've done on mandates that have forced so many small employers out of the market because you have made the plans so expensive that small employers don't afford them."

So there's always two sides to the story, and that's why we have a diverse group on this commission. And I would also suggest to the audience we have good consumer representation on here. I think you have some very strong consumer advocates. You have business advocates. You have HMO advocates. And what I think is good is that we can come and air our different views and hopefully come to some recommendations, and my suspicion is we'll have different recommendations with people who think differently, and that's part of life.

CHAIRMAN ENTHOVEN: Thank you. Peter, oh sorry. Do you have something on that, Michael?

MR. SHAPIRO: Actually, I had a paperwork request. A lot of us are intrigued by the President's task force including the meeting, is there without

approaching too much to what degree in the staff the task force gathers and share information among the task force members on issues you're looking at that are relevant to what we're doing? Others of us will be doing that individually, and I've been asked to share to the extent of the legislature --

CHAIRMAN ENTHOVEN: As long as they save us the Xeroxing cost.

MS. SKUBIK: They have a web page that has all of their proceedings, all of their minutes, all of their materials which you can just refer to directly.

MR. SHAPIRO: Can someone --

MR. LEE: I'll give that to you. The web site is: HCqualitycommission.gov, but it's overloaded, and I've had trouble getting on it and getting stuff off and had trouble getting on to it. And they have a delay in terms of getting things that are quite current. And I think it wouldn't behoof the task force staff to get the most up-to-date background papers on a number of issues that are quite relevant. I've gotten some that I've saved on resolution. There are a number of groups and chapters that I think should be distributed besides having task force members go through the web site. But when you can get on, it's very good.

UNIDENTIFIED SPEAKER: What's the address again?

MR. LEE: HCqualitycommission -- no spaces in there -- .gov.

MR. ZATKIN: It's shorter than ours.

MR. LEE: It is a little shorter than ours.

CHAIRMAN ENTHOVEN: But it's harder to get on to.

MR. LEE: Well, it may well have in front of it "http."

CHAIRMAN ENTHOVEN: Jeanne?

MS. FINBERG: Yeah, on the federal legislation I just wanted to mention something that is relevant to our discussion of recommendations, maybe more to the last subject we were talking about disclosure. There's been a change in federal law about the PSOs that provide service organizations being able to do direct contracting with Medicare, hospitals and doctors contract with Medicare. I think it's very relevant to the issues we're talking about with medical groups and information and regulation. It kind of raises some of the stakes so that group or our experts I think need to be sensitive to that in terms of what recommendations we'll be making that is a real changing environment.

CHAIRMAN ENTHOVEN: Right.

MS. BOWNE: But, Jeanne, in response to that the federal legislation on PSO specifically says that they must meet all state consumer and quality protections and all Medicare plus choice or the old Medicare risk, so they have to meet both.

CHAIRMAN ENTHOVEN: Does that mean Knox-Keene license?

MS. FINBERG: I would say that the consumer protections are not as stringent as they are now, and it causes us some concern. And I do believe that the elimination of that licensure employment will make a big difference.

MR. ZATKIN: I thought that they had to be part of them, but there was a question -- I mean, they were allowed to move the federal status if they weren't dealt with in timely fashion by the state.

MS. BOWNE: No, basically there are four principles. If you'd like a summary, I'll give it to you, but there are four ways, and they have to go through the state first, and the feds may delegate to the state oversight of quality and consumer activity, so they'll be right back in the lack of state group.

MR. LEE: Alain, if I could just wrap up our area which is foreshadowing the other two issues which the other people are still left thinking about, which is when we get another opportunity to talk about this is the other area that Barbara and I wrestled with the most, and we'd like the task force to talk about more is external processes, so to speak, in terms of what circumstances should there be independent assistance to consumers having problem navigating such as the pilot program we're working on in fact now. And what circumstances should there be third party review in

medical assessment issues.

Those are two issues we think the task force needs to spend some time looking at, how to have those systems support early resolutions, support sufficiency, but still be safety valve and discuss how those sorts of systems can be part of restoring trust, et cetera. The other ones we didn't want to get into them because we didn't have any time.

CHAIRMAN ENTHOVEN: Okay. That's great. Thank you very much, Barbara and Peter. I really appreciate what you've done. I apologize, Clark, that we've run out of time, but I think we had a great discussion.

There is one more member of the public who has asked for an opportunity to speak, Mr. Warren Leach. Is Mr. Leach here from Coopertino to speak about SB 1220 Diabetic Supply Bill?

Welcome to our task force, Mr. Leach.

MR. LEACH: Basically, my name is Warren Leach. I'm from Coopertino --

CHAIRMAN ENTHOVEN: You'll have to use the mic.

MR. LEACH: I had the privilege of testifying before you folks in Sacramento, and I became aware of SB 1220 which is a bill that would mandate diabetics supplies in the state. The Presidential Commission you referred to earlier advised me that the Medicare program is already mandated these diabetic

supplies that are test strips. I have my kit with me. The strips, you buy them for about $35. The machine's about $45 plus rebates. They cost about 70 cents a piece, and the Bill SB 1220 would mandate the dispense, free dispense of these strips by HMOs.

Let me just briefly tell you what my situation is on these strips. I'm with FHP which was taken over by PacifiCare, and they would provide the strips for $5 copayments, so I would end up getting a hundred strips. I changed health plans in January this year to Health Net and went down as my prescription simply don't pay for these. So I called them several times, and he says, "You got to change meters." I said, "I'm not going to change meters."

So I called back several more times and they said, "We got good news and bad news. The good news is we're going to give you free strips. The bad news they come from Santa Fe Springs by UPS," so that's what the situation is today. It seems to be in consistency with these type of devices.

And the -- my hospital bills as I referred to you last time from my heart attack was about 65, 70 thousand dollars, and that would pay for a lot of strips. And previous incident, Stanford the year before, I had a stroke. And the hospital bill was 15,000, so what I'm saying to you now an ounce of prevention is worth a pound of cure, and these devices for people who have medical problems like I have, they

should be mandated by law. Thank you very much.

CHAIRMAN ENTHOVEN: Mr. Leach, let me ask you if you just paid for all those yourself out of pocket, what would a year's supply cost?

MR. LEACH: Well, they come in packages of 50 in a vial, and it's about $35 if I was to pay for them, each vial.

CHAIRMAN ENTHOVEN: How many does $35 give you?

MR. LEACH: Every time you're testing, you're testing once or twice a day like I used to do, so you can calculate that by 365 how much they would cost. Now I'm doing it two, three times a day, and so you can calculate, you know, what the cost is by 70 cents.

CHAIRMAN ENTHOVEN: 70 cents a day?

MR. LEACH: 70 cents each strip.

CHAIRMAN ENTHOVEN: So $2.10 a day.

MR. LEACH: You can't reuse the strips. You can't reuse the alcohol Schwabs. The syringes I can reuse. And the lancets I can reuse, but the diabetic strips and the alcohol Schwabs you can't reuse, and of course you have to buy insulin, and whatever else.

But what I'm saying to you is an ounce of prevention is worth a pound of cure, and this does not fall too well with the HMOs, and I noticed in the Wall Street Journal article that the average cost for an employee was around $4,000. It also mentioned a group called Pacific Business Group of Health. And I called

the reporter and found out where they're located, and I got their phone number, and I called. And then they sent me a membership package, and you probably know from that group it's who's who in business in California and the west coast. And these people -- groups, they negotiate with HMOs on the rates, and I suspect sometimes that these rates that they sometimes beat down the HMO, and the HMO takes it out on the enrollee. So I think that this false economy here as far as prevention of serious medical problems.

CHAIRMAN ENTHOVEN: Okay. Thank you, any questions of members?

DR. ROMERO: Just a suggestion, sir. I happen to have some personal knowledge of this bill because I'm involved extracurricularly with the local board of my local chapter of the American Diabetes Association, and I can confirm with the financial side of what you're saying that these things are moderately expensive, you said roughly $2.10 a day. That's 700 to 800 dollars a year, but as most of us know can prevent much more expensive acute procedures later.

I would encourage you if you had not done so -- well, I'll make a comment first. This task force has been asked -- has been asked specifically to deal with broad issues, so we'll be dealing with the broad issues that you just described, but we will not be opining specific bills in front of the legislature this year. And if you would like to have your voice heard on

this bill in addition to writing Senator Solis, write Governor Wilson.

MR. LEACH: They tell me that the governor's office has not indicated its pleasure or displeasure of the bill.

DR. ROMERO: And I can't enlighten you further because I don't know either, but if you had not written, I encourage you to do so.

MR. LEACH: I will.

DR. ROMERO: Thank you.

CHAIRMAN ENTHOVEN: All right. Without objection we will consider the meeting to be closed.

(Whereupon the proceedings were concluded at 4:50 p.m.)

STATE OF CALIFORNIA)
) ss.
COUNTY OF ALAMEDA)

I, Jennifer Arroyo, CSR 10696, a Certified Shorthand Reporter in and for the State of California, do hereby certify:

That the foregoing proceeding was taken down by me in shorthand at the time and place named therein and was thereafter reduced to typewriting under my supervision; that this transcript is a true record of the testimony given by the witnesses and contains a full, true and correct record of the proceedings which took place at the time and place set forth in the caption hereto as shown by my original stenographic notes.

I further certify that I have no interest in the event of the action.

EXECUTED this _____day of _____, 1997.

_____
Jennifer Arroyo, CSR #10696